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HOUSE OF REPRESENTATIVES

REPORT
No. 96-190

HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1979

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

ADDITIONAL VIEWS

[To accompany H.R. 3917]

[And Including Cost Estimate of the Congressional Budget Office]

MAY 15, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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HEALTH PLANNING AND RESOURCES DEVELOPMENT AMENDMENTS OF 1979

MAY 15, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 3917]

[Including the Congressional Budget Office cost estimate]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (3917) to amend titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those titles for health planning and health resources development, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 6, line 5, strike out "(11)" and insert in lieu thereof "(12)".
Page 6, line 7, strike out "(12)" and insert in lieu thereof "(13)".
Page 6, line 12, strike out "(13)" and insert in lieu thereof "(14)".
Page 6, line 17, strike out "(14)" and insert in lieu thereof "(15)".
Page 9, line 1, strike out "(10)" and insert in lieu thereof "(11)".
Page 13, line 3, insert before the close quotation marks the following:

> Before the Secretary may permit the term of an agreement to expire without renewing the agreement, the Secretary shall make the consultations prescribed by clause (i) and the preceding sentence, give the entity with which the agreement was made notice of the intention not to renew the agreement and the reasons for not renewing the agreement, and provide, as prescribed by clause (iii), the entity an opportunity for a hearing on the matter specified in the notice.

Page 13, insert after line 25 the following:

(h) Section 1515(c)(3) is amended by adding at the end the following: "If the Secretary determines that a health systems agency has not met such requirements, the Secretary may impose in the renewal of the designation agreement of the agency such conditions as the Secretary determines are necessary to assure that the agency will meet such requirements before the expiration of the period for which the agreement is renewed. The Secretary may not impose on a health systems agency any such conditions unless the Secretary has—

"(A) provided the agency with notice of his intent to impose such conditions and included in that notice specification of the requirements which the Secretary has determined the agency has not met and the basis for the determination of the Secretary that the imposition of such conditions is necessary to assure compliance with such requirements; and

"(B) provided the agency with a reasonable opportunity for a hearing, before an officer or employee of the Department of Health, Education, and Welfare designated for such purpose, on the conditions.".

Page 19, line 25, insert "broadly representative of the health service area and" after "(II)".

Page 47, line 13, strike out "(11)" and insert in lieu thereof "(12)".

Page 50, strike out lines 1 through 5 and insert in lieu thereof "Agency.".

Page 52. insert after the period in line 9 the following:

If a letter of findings of noncompliance with the requirements of title VI of the Civil Rights Act of 1964 has been issued by the Secretary to an applicant for a certificate of need, the State Agency may defer providing the notice required by section 1532(b)(1) until—

"(I) the Secretary has issued to the applicant a letter of findings of compliance with such requirements, or

"(II) in the administrative process begun by the issuance by the Secretary of a notice of deferral of Federal financial assistance a final decision of compliance with such requirements has been made or upon judicial review of a decision made in such administrative process a final decision of compliance with such requirements has been made,

whichever occurs first. If after a review of an application for a certificate of need has begun a letter of findings of noncompliance with the requirements of such title VI is issued to the applicant by the Secretary, the State Agency may suspend review of the application during the period beginning on the date such letter is issued and ending on the date whichever of the actions referred to in subclause (I) or (II) occurs and any period during which such review is so suspended shall not be counted in determining if the review has been completed within the time period prescribed by this subparagraph.

Page 61, line 1, strike out "not".

Page 61, line 4, strike out "unless" and insert in lieu thereof "if".

Page 76, line 5, insert before the close quotation marks the following:

> Before the Secretary may permit the term of an agreement to expire without renewing the agreement, the Secretary shall make the consultations prescribed by clause (i) and the preceding sentence, give the State Agency with which the agreement was made notice of the intention not to renew the agreement and the reasons for not renewing the agreement, and provide, as prescribed by clause (iii), the State Agency an opportunity for a hearing on the matter specified in the notice.

Page 84, line 8, strike out "1981" and insert in lieu thereof "1982".

Page 84, line 24, strike out "1981" and insert in lieu thereof "1982".

Page 96, line 20, strike out "organization, operation" and insert in lieu thereof "organizational, operational".

Page 97, line 1, insert ", consistent with State law respecting foreclosure procedures," after "action".

Page 97, line 4, insert "for a reasonable period of time" after "including".

I. Legislative Background

Legislation to amend Titles XV and XVI of the Public Health Service Act to revise and extend the authorities under the act for health planning and resources development, H.R. 3041, was introduced on March 15, 1979, by Mr. Waxman, Chairman of the Subcommittee on Health and the Environment for himself and Mr. Preyer, Mr. Maguire, Mr. Walgren, Mr. Leland, Mr. Carter, and Mr. Stockman.

Hearings were held on H.R. 3041 and all similar or identical bills on March 28 and 29, 1979. The bill was subsequently considered in open executive sessions by the Subcommittee on Health and the Environment, amended, reported and introduced as a clean bill H.R. 3917 on May 3, 1979, by Mr. Waxman and twelve other members of the committee.

H.R. 3917 was considered by the Interstate and Foreign Commerce Committee on May 15, 1979, amended, ordered reported by voice vote.

II. Summary of the Legislation

The purpose of this legislation is to amend and extend title XV and XVI of the Public Health Service Act dealing with health planning and resources development. These titles were established by Public Law 93–641, "The National Health Planning and Resources Development Act of 1974."

As reported, H.R. 3917 would extend and modify existing requirements with respect to health systems agencies, State health planning, Federal health planning and policy making, and resources development. The major provisions of the proposed legislation are summarized below.

1. The legislation would strengthen the linkages between local and State health planning and that which takes place at the Federal level. The Secretary would be required to analyze and review the health

plans which are developed by the health systems agencies (HSAs) and States and use that analysis in modifying the national guidelines for health planning or in developing additional guidelines. The bill makes it clear that the national guidelines for health planning are not to be rigid standards inflexibly applied but rather benchmarks which HSAs can adjust as local circumstances require.

2. The bill recognizes those circumstances in which competition may serve to allocate the supply of health services and encourages planning agencies to work to strengthen market forces.

3. The legislation requires each State health planning and development agency (SHPDA) to establish a statement of statewide health needs at the beginning of the planning process, which the HSAs would consider in developing their plans.

4. The bill increases the role of the Governor in area and HSA designation and allows the Governor to disapprove the State health plan if it does not meet statewide health needs.

5. Provisions in the bill are made for more active local elected official participation in the health planning process.

6. The bill modifies some of the compositional requirements of HSA governing bodies.

7. The bill increases the amount and flexibility of financial support available for HSAs.

8. The bill provides for the integration of planning for mental health, alcoholism and drug abuse with the planning system established by Title XV.

9. Requirements would be added to existing law to make plans which HSAs develop more detailed and to allow plan adoption only after public hearings have been conducted.

10. The legislation extends the minimum coverage of a certificate of need program to the purchase of major medical equipment which will serve inpatients of a hospital (except that such equipment purchased by independent clinical laboratories is not required to be covered).

11. The bill requires a State to exempt from a certificate of need program the proposals of health maintenance organizations, providers of ambulatory and inpatient services on a prepaid basis, and other providers who enter into agreements to provide service to enrollees of HMOs and other such prepaid providers.

12. The legislation requires that an application for a certificate of need be reviewed within a prescribed time or else it will be deemed approved.

13. The bill would allow a certificate of need applicant to designate data which he believes should not be released to the public and to submit such data separately. If the agency proposes to release such data it shall notify the applicant at least 30 days before the release.

14. The legislation requires health planning agencies to coordinate their activities with rate review entities.

15. The bill authorizes grants to States for the purpose of demonstrating the effectiveness of alternative means for reducing excess hospital capacity.

16. The bill would allow the Secretary to extend a SHPDA's conditional designation beyond 36 months if the SHPDA is making a good faith effort to comply with the law.

17. The bill reduces and delays the penalty on a State not having a fully designated SHPDA to allow the State time to meet the requirements of this bill.

18. The legislation requires approval of an application for a certificate of need if it is required to eliminate or prevent imminent safety hazards or comply with licensure or accreditation standards, but only for those capital expenditures required to eliminate or prevent such hazards or to comply with such standards.

19. The bill would extend to non-profit hospitals the same financial assistance available to public medical institutions to undertake necessary modernization projects.

20. The bill would extend Federal loan and loan guarantee programs to support health care facility development although support would be limited to priority areas. The legislation would repeal the provisions of existing law which have provided allotment grants to States to develop health care facilities.

21. Grant authority for the construction of outpatient medical facilities in medically underserved areas and the conversion of existing facilities into facilities for outpatient and long term care would be established by the bill.

22. The legislation would establish a program to assist and encourage the discontinuance of unneeded hospital services by providing financial assistance to hospitals who voluntarily close or convert part or all of their facility.

III. Cost of Legislation

As reported by the Committee, H.R. 3041 provides authorizations of appropriations for fiscal years 1980, 1981, and 1982 in the amounts shown in the following table.

AUTHORIZATIONS OF APPROPRIATIONS FOR FISCAL YEARS 1980, 1981, 1982 PROVIDED BY H.R. 3041

[In millions of dollars]

	Fiscal year			
	1980	1981	1982	Total
Title XV:				
Health systems agency planning grants (sec. 1516)	150	160	170	480
State health planning and development planning grants (sec. 1525)	35	37	39	111
Rate regulation grants (sec. 1526)	6	7	8	21
Grants for reduction of excess capacity (sec. 1528)	4	4	4	12
Centers for health planning (sec. 1534)	10	11	12	33
Subtotal	205	219	233	657
Title XVI:				
Project grants for modernization of public hospitals (sec. 1625(a))	50	50	50	150
Project grants for outpatient and long-term facilities (sec. 1625(b))	15	15	15	45
Area health service development grants (sec. 1640)	25	40	50	115
Project grants for closure and conversion (sec. 1643)	50	75	100	225
Subtotal	140	180	215	535
Total authorization levels	345	399	448	1,192

These figures may be compared with the recent budgetary authorizations of title XV and XVI.

AUTHORIZATIONS/APPROPRIATIONS UNDER PUBLIC LAW 93-641

[In thousands of dollars]

	Authorizations					Appropriation					
	1975	1976	1977	1978	1979	1975	1976	1977	1978	1979	1980[1]
TITLE XV											
Health systems agencies	60,000	90,000	125,000	125,000	125,000	----	64,090	97,000	107,000	107,000	115,400
State agencies	25,000	30,000	35,000	35,000	35,000	----	19,000	24,500	29,500	29,500	30,000
Rate regulation	4,000	5,000	6,000	6,000	6,000	----	----	2,000	2,000	[2]	----
Centers for health planning	5,000	8,000	10,000	10,000	10,000	10,000	7,500	6,500	6,500	6,500	----
TITLE XVI											
Area health services development	25,000	75,000	120,000	120,000	120,000	----	----	----	----	----	----
Health facilities construction:											
Sec. 1602 formula grants	125,000	130,000	135,000	135,000	135,000	----	[3]51,760	----	----	----	----
Sec. 1625 project grants	----	----	----	67,500	67,500	----	----	----	----	----	----
Closure and conversion	----	----	----	----	----	----	----	----	----	----	30,000
Total	244,000	338,000	431,000	498,500	498,500	10,000	142,350	130,000	145,000	143,000	175,000

[1] Administration proposal.
[2] Program budget transferred to HCFA.
[3] 22 percent may be used for sec. 1625 project grants.

Source: Bureau of Health Planning, Office of Policy Development, Feb. 8, 1979.

IV. Brief History and Need for Legislation

Congressional interest in effective health planning and resources development began with the enactment of the Hill-Burton program, (Public Law 79–725) in 1946. Not only did this program provide funds for the construction of needed hospitals but it clearly contemplated that the States which received those funds would use them in accordance with a planning process. States were to determine their need for additional medical facilities and develop plans to use the available funds to fill unmet needs.

Few substantive changes were made in the Hill-Burton program until 1964 when it was amended to include new authority for the funding of regional, or areawide, voluntary health facilities planning agencies (sometimes called "318 agencies" after the section of the Public Health Act under which they were authorized. This new authority rapidly led to the funding in a number of major metropolitan areas of nonprofit private corporations governed by boards of community leaders and health care providers which sought to plan for the development of needed hospitals and other health care facilities in their communities.

The 89th Congress saw the enactment of Medicare and Medicaid programs providing for the first time for extensive Federal participation in the financing of health care services. The Heart Disease, Cancer, and Stroke Amendments of 1965 (Public Law 89–239) and the Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89–749) which established the regional medical program (RMP) and the comprehensive health planning program (CHP) respectively, were also products of the 89th Congress.

While the Hill-Burton, RMP, and CHP programs had the common goal of improving the health of the American people and made impressive contributions to better resource availability, their efforts were also marked by lack of adequate financing, overlap and duplication of responsibilities, absence of a sufficient mandate for implementation of their authorities, inadequate coordination between the planning bodies and the various public agencies responsible for funding health resources development, and lack of general guidance as to national health priorities and goals. Because of its growing concern with respect to the increasing costs of health care and the failure of the existing programs to rationalize the delivery of health care services, the committee conducted extensive hearings in 1974 on legislation which substantially revised and strengthened both the health planning and resources development functions of the existing authorities.

After many months of hearings and debates, the Congress concluded that previous attempts to plan for health services and to develop resources in a rational manner had not been successful and that there was a need to restructure and strengthen areawide and State planning for health services, manpower, and facilities. It was also evident that a national health planning policy which could provide guidance for the development of resources throughout the nation (especially medical facilities and new technology) and assistance in setting priorities for Federal programs and investments was required.

In the absence of clear national goals and guidelines (and internally consistent Federal policies), programs aimed at improving the system had been fragmented and uncoordinated—continuing or exacerbating existing problems of maldistribution and spiraling costs. Inadequate incentives to use appropriate levels of care and for the substitution of ambulatory, intermediate and home health care—all less expensive than inpatient care—were found to have contributed to the cost spiral. The massive infusion of Federal funds in the 1970's into the existing system—with no cost containment incentives, indeed with a number of cost inflating pressures—contributed to the increase, and yet failed to produce an adequate supply or distribution of health resources for all parts of the country.

The most serious problems confronting the nation as a whole related to the burgeoning costs of health care and the seemingly endless possibilities for care which resulted from the technological and biomedical discoveries of the previous 20 years. These latter two forces—cost increases and technological advances—coupled with the growth in the number of elderly with their higher service needs, and the shift from the predominance of acute and infectious conditions to chronic health problems—spotlighted a need for, and triggered widespread interest in, improved health planning and resources distribution in this Nation. Congressional consideration culminated in the enactment of the National Health Planning and Resources Development Act of 1974, Public Law 93–641, which was signed by President Ford on January 4, 1975.

The passage of Public Law 93–641 was intended to provide new and improved structure and support for effective health planning and a more systematic development of resources, especially new technology. Based on its study of the predecessor programs, Congress chose to combine the best features of these earlier efforts into a single new Fed-

eral, State, and areawide program for health planning and resources development rather than continue all of the programs then in existence as separate activities or extend one at the expense of the others. Each of the former programs had compiled an impressive list of accomplishments; yet their uncoordinated, simultaneous existence, however, had left parts of the country without areawide or regional planning, had led in some communities to conflicts and difficulty in defining appropriate roles, and had necessarily resulted in some duplication of effort, inefficiency, and wasting of scarce Federal resources and even scarcer expert staff.

The need for strengthened and coordinated planning for personal health services is growing increasingly more apparent as health care costs continue to rise rapidly. At the present time much of the health care industry does not respond to classic marketplace forces. The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs so that choices are not based on the price of a service, thus reducing the patient's immediate incentive to contain expenditures.

Investment in costly health care resources, such as hospital beds, coronary care units and CT scanners has frequently been made without regard to the existence of similar facilities or equipment already operating in an area. Investment in costly facilities and equipment not only results in capital accumulation, but establishes an ongoing demand for payment to support those services. There is convincing evidence from many sources that overbuilding facilities has occurred in many areas, and that maldistribution of high cost services exists.

At the same time, widespread access and distribution problems exist with respect to medical facilities and services. In many urban areas, hospitals, clinics and other medical care institutions and services are crowded into relatively tiny sectors, while large areas go poorly served or completely unserved. Many rural communities are without a physician or any other type of health care service, while adjacent urban areas are oversupplied.

The health planning program is designed so that decisions about health care needs and priorities are made at the local level by organizations composed of consumers, local elected officials and providers working together and in conjunction with State governments. By carrying out planning, review and implementation activities HSAs and State planning agencies seek to assure the rational development of institutional health services, help coordinate federal investment in local areas, identify unmet needs and work with others to design programs to meet those needs, and identify services where excess capacity exists and encourage its reduction.

The goal of the health planning program—to provide access to quality care at a reasonable cost—is as important today as it was in 1974 when this legislation was enacted. Many sectors of our Nation, particularly rural areas, do not have access to even basic medical services. Health systems agencies (HSAs) and State health planning and development agencies (SHPDAs) are working with local groups to

attract necessary medical resources to those areas. It is clear that the rapid rise in health care costs presents us with a major problem. Health planning agencies are working on this problem through the review of new institutional health services by assuring that only those services and facilities which are needed are allowed to be developed and constructed. Excess hospital capacity is also a problem for some areas and health planning agencies are working with local communities to consolidate health care facilities to use existing facilities to provide alternative services as appropriate. Good health planning is essential if we are to successfully meet these needs and improve the efficiency of our health care delivery system.

V. Description of Existing Law (Public Law 93–641)

OVERVIEW

The National Health Planning and Resources Development Act of 1974, P.L. 93–641, was composed of two principal parts. The first added a new title XV to the Public Health Service Act—National Health Planning and Development—as a replacement for previous health planning initiatives authorized under the Regional Medical Program and the Comprehensive Health Planning Program. The second, added a new title XVI to the PHS Act for Health Resources Development—as a replacement in large part for the Hill-Burton medical facilities construction program. Although the Hill-Burton program was not actually repealed and the requirements pertaining to facilities funded under its authority were to remain in effect, the new title XVI program was to be the conduit for future allocation of Federal funds for construction, modernization, and conversion of health facilities.

Part A of the new title XV established a National Council on Health Planning and Development and directed the Secretary of HEW to issue national guidelines for health planning. Part B of the new title created a system of health systems agencies (HSAs) responsible for areawide health planning and development throughout the country. Part C of the title provided assistance to State governments in the development and funding of State health planning and development agencies (SHPDAs). Part D contained general provisions applicable to the above programs, including authorization for regional centers for health planning. Parts A, B, C, and D of the new title XVI revised the program of State allotments, loans and loan guarantees, and special project grants for health facilities construction, modernization, and conversion. Part E of the new title XVI contained general provisions relating to the foregoing programs. Part F provided area health services development funds to HSAs for their use in development of health resources designed to implement their health plans.

NATIONAL GUIDELINES FOR HEALTH PLANNING

The law directed the Secretary of HEW to issue, within 18 months of enactment, guidelines concerning national health planning policy and to revise such guidelines as deemed appropriate. In issuing guidelines, the Secretary was to include standards respecting the appro-

priate supply, distribution, and organization of health resources and a statement of national health planning goals expresed to the maximum extent practicable in quantitative terms. Recommendations and comments were to be solicited from HSAs, SHPDAs, Statewide Health Coordinating Councils, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development (sec. 1501).

NATIONAL HEALTH PRIORITIES

The legislation included a list of national health priorities which were to be given special consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs. The priorities included:

(1) Provision of primary care services for medically underserved populations, especially those located in rural or economically depressed areas;

(2) Development of multi-institutional systems for coordination or consolidation of institutional health services;

(3) Development of medical group practices, health maintenance organizations, and other organized systems for provision of health care;

(4) Training and increased utilization of physician assistants, especially nurse clinicians;

(5) Development of multi-institutional arrangements for sharing of support services necessary to all health service institutions;

(6) Promotion of activities to achieve needed improvements in quality of health services, including needs identified by professional standards review organizations under title XI of the Social Security Act;

(7) Development by health service institutions of capacity to provide various levels of care on a geographically integrated basis;

(8) Promotion of disease prevention activities, including studies of nutritional and environmental factors affecting heatlh and the provision of preventive health care services;

(9) Adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions; and

(10) Development of effective methods for general public education about proper personal health care and effective use of available services (sec. 1502).

NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

The law established in the Department of HEW an advisory council known as the National Council on Health Planning and Development. The Council was charged with responsibility for advising, consulting with, and making recommendations to the Secretary with respect to (1) development of the national guidelines: (2) the implementation and administration of the programs established under the Act; and (3) evaluation of implications of new medical technology

for the organization, delivery, and equitable distribution of health care services.

The Council was to be composed of 15 members, with the Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense and the Assistant Secretary for Health of the Department of HEW included as nonvoting ex officio members. The remainder were to be appointed by the Secretary to serve for staggered six year terms and were to include persons who, as a result of their training, experience or attainments, were exceptionally well qualified to assist in carrying out the Council's functions. Not less than five were to be persons who were not health care providers, not more than three were to be Federal employees, not less than three were to be members of HSA governing bodies, and not less than there were to be members of Statewide Health Coordinating Councils (SHCCs). In addition, the two major political parties were to be equally represented. Voting members were to select a Chairman from among their number. Council members were to be compensated and allowed to appoint, fix the pay of, and prescribed the functions of supporting staff. In addition, the Council could utilize the services of experts and consultants (sec. 1503).

HEALTH SERVICE AREAS

Under the law the Governor of each State was to designate the boundaries of health service areas for which health systems agencies were to be designated.

Health service areas were to be geographic regions appropriate for the effective planning and development of health services, determined on the basis of such factors as population and the availability of resources to provide all necessary health services for area residents. To the extent practicable, each area was to include at least one center for the provision of specialized health services. A health service area could encompass a maximum population of three million except in areas which included a Standard Metropolitan Statistical Area (SMSA) of more than three million. The minimum population size for an area was to be 500,000 except that it could be as low as 200,000 in unusual circumstances and below 200,000 in highly unusual circumstances. To the maximum extent feasible, the area was to be coordinated with other relevant existing geographic areas including Professional Standards Review Organization areas and existing regional planning and State planning and administrative areas.

The boundaries were to be established so as to recognize the differences in health planning and resources development needs between nonmetropolitan and metropolitan areas and to take into account any economic or geographic barrier to receipt of services in nonmetropolitan areas. Each SMSA was to be entirely contained within the boundaries of one health service area unless, with the Secretary's approval, the Governor of each State in which an SMSA was located determined otherwise.

Boundaries were to conform to those of the pre-existing 314(b) comprehensive health planning agencies if the areas encompassed by these former agencies met the designation requirements. The Governor could waive this requirement if he found that the designation of another

area was more appropriate for effective planning and development of health resources.

The law detailed the procedures to be followed in the designation process. The areas proposed by the Governors were to serve as the official boundary designations unless they were inconsistent with the law's requirements or did not include a portion of the United States. In such instances, the Secretary was given authority to make necessary changes. The initial designation process for all States (except those specifically exempted under section 1536 discussed below) was to be completed by January 4, 1976.

The appropriateness of boundary designations was to be reviewed by the Secretary on a continuing basis. Revisions could be initiated either by the Secretary, the Governor, or designated health systems agencies, but revisions could only be made, after consultation with Governors and appropriate agencies, if the Secretary determined that the boundary no longer met the specified requirements (section 1511).

HEALTH SYSTEMS AGENCIES

The law provided for the creation of a nationwide network of health systems agencies (HSAs) responsible for areawide or regional health planning and resources development in their respective health service areas. Health systems agencies could be either non-profit private corporations or public entities. A nonprofit private corporation (or similar legal entity) : (1) was required to be incorporated in the State in which the largest part of the population of its health service areas resided; (2) could not be a subsidiary of or otherwise controlled by another public or private entity; and (3) could only engage in health planning and development functions.

A public entity could be either (1) a single unit of general local government if its area of jurisdiction was identical to that of the applicable health service area, or (2) a public regional planning body which had a planning area identical to the health service area and either had a governing board (the majority of the members of which were elected local officials) or was authorized by State law (in effect prior to the enactment) to carry out requisite health planning and review functions. Health systems agencies were prohibited from being or operating an educational institution.

HSAs were to employ staff who possessed expertise in administration, gathering and analysis of data, health planning, and in the development and use of health resources. The functions of planning and development of health resources were to be conducted by staffs with skills appropriate to each function. Each HSA was to have a minimum staff of five professionals, or one professional (up to 25) for every 100,000 persons in the area, whichever was greater. Methods of selection, compensation, promotion, and discharge of staff members were to be determined by each agency, with the stipulation that renumeration for any position be at least equal to that for comparable positions in the area. The agency could also employ consultants and contract with individuals or entities for the provision of services.

Public HSAs were required to have a separate governing body for health planning with exclusive authority to perform the requisite planning functions. Private HSAs were required to have a governing

body composed of 10–30 members except that the number could exceed 30 if the governing body established an executive committee, composed of up to 25 members of the full governing body and delegated its authority to act to the committee (except for the establishment of health plans).

The governing body was given responsibility for the internal affairs of the agency, establishment of a health system plan (HSP) and annual implementation plan (AIP), approval of grants and contracts awarded to implement these plans, approval of actions taken pursuant to agency review functions, issuance of an annual report, and additional functions relating to its operation. The governing body could act only upon a majority vote of its members, a quorum (50 percent) being present, at a meeting called upon adequate notice to all its members.

Consumers were to fill a majority (but not more than 60 percent) of the membership positions on the governing body and executive committee. The remaining members were to be health care providers residing in the area who represented health professionals (including physicians, particularly practicing physicians, dentists, nurses, and others); health care institutions (particularly hospitals, long-term care facilities, and health maintenance organizations); health care insurers; health professional schools; and the allied health professions. At least one third of the provider members were required to be direct providers of health care, as opposed to indirect providers defined as individuals: (1) holding a fiduciary position with, or fiduciary interest in entities engaged in provision of health care or in such research or instruction, or entities engaged in drug manufacture; (2) receiving (either directly or through one's spouse) more than one-tenth of gross annual income from research or instructions in or provision of health care, or from manufacture of drugs or other articles used in health care; (3) who were members of the immediate family of a direct or indirect provider; or (4) employed by health insurers.

Membership was to include (either as consumer or provider representatives) public elected officials, other representatives, of local governmental authorities, representatives of local public and private health agencies, and a proportional percentage of residents of the nonmetropolitan areas within the service area. Where the health service area included a hospital or other health facility of the Veterans' Administration or a qualified health maintenance organization, HSA membership was to include at least one representative of such an entity, in the case of the VA representatives on an ex officio basis. Any subcommittees or advisory groups appointed by the governing body or executive committee were to be composed to the extent practicable in a similar manner.

Consumer members were to be residents of the health service area who were not (or within the 12 months preceding appointment had not been) providers and who were broadly representative of the social, economic, linguistic, and racial population, geographic areas of the health service area, and major purchasers of health care.

The law provided that members or employees of HSAs were to be exempt from civil liability in the performance of their functions, pro-

vided such individuals had acted within the scope of their responsibilities, exercised due care, and acted without malice.

HSAs were precluded from accepting funds or other contributions of facilities or services from individuals or entities with a financial or other direct interest in the development, expansion, or support of health resources. Agencies were permitted to accept contributions from charitable foundations such as those described in section 509(a) of the Internal Revenue Code of 1954, provided such entities were not directly engaged in the provision of health care in the area.

Health systems agencies were required to make reports and keep records as required by the Secretary, provide for such fiscal control and fund accounting procedures as he might require, and permit the Secretary and Comptroller General access to records and documents.

Subarea councils meeting the composition requirements for HSAs could be established by the HSA to advise the governing body on performance of its functions (sec. 1512).

FUNCTIONS OF HEALTH SYSTEMS AGENCIES

The primary responsibility of each HSA was the provision of effective health planning for its health service area and the promotion of the development of services, manpower, and facilities which met identified needs, reduced documented inefficiencies, and implemented the health plans of the agency. HSAs were to undertake this responsibility in order to: (1) improve the health of area residents; (2) increase accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of health services; (3) restrain increases in the cost of health services; and (4) prevent unnecessary duplication of health resources. To meet this responsibility, each agency had to perform specified functions.

Each agency was required to collect and analyze health data for its area utilizing wherever possible existing data. After consideration of this data, national guidelines for health planning, and national health priorities, the agency was required to establish, annually review, and revise as necessary a health systems plan (HSP). Each HSP was to be a detailed statement of goals: (1) describing a health system which would assure availability and accessibility of quality health services, continuity of care, and reasonable cost of services; (2) responsive to the unique needs and resources of the area; and (3) which took into account and was consistent with the national guidelines. The agency was required to conduct a public hearing prior to establishing the HSP.

As an adjunct to the HSP, the agency was also required to establish an annual implementation plan (AIP) describing objectives to achieve the goals of the HSP and priorities among these objectives. It was also required to develop and publish specific plans and projects to achieve these objectives.

In implementing its HSP and AIP, each health systems agency was required to perform the following functions: (1) implement plans to the extent practicable with the assistance of individuals and public and private entities in the area; (2) provide, in accordance with AIP priorities, technical assistance to achieve the health system described in the HSP; and (3) in accordance with AIP priorities, make grants

to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entities for planning and developing projects and programs to achieve the health system described in the HSP. Grants and contracts for such purposes were to be made from the Area Health Services Development Fund, and could not be applied toward the costs incurred in delivering health services or the construction or modernization of facilities. Grants and contracts were limited to a one-year period with each individual or entity eligible for a maximum of two awards for any project or program.

Each agency was required to coordinate its activities with, secure appropriate data from, to the extent practicable provide technical assistance to, and enter into agreements with Professional Standards Review Organizations (established under section 1152 of the Social Security Act), and other appropriate general or special purpose regional planning or administrative agencies or other appropriate entities.

Each HSA was given responsibility to review and approve or disapprove the proposed uses within its area of Federal funds under the Public Health Service Act, the Community Mental Health Centers Act, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans or loan guarantees for the development, expansion, or support of health resources. Such review was to extend to Federal funds made available by the State from an allotment to the State under the authorities mentioned above. Review of funds for grants or contracts under titles IV, VII, or VIII of the PHS Act was restricted to projects involving development of health resources intended for use in the area or for the delivery of health services. The HSA was also required to inform Indian tribes of the availability of Federal funds; however, it could only review and comment on the proposed use of Federal funds located within certain Indian areas.

The Agency was given 60 days to make any required review. If an agency were to recommend disapproval of proposed expenditures, the Secretary could not make funds available until he had made, upon request of the entity making the proposal, a rewiev of the agency decision. In reviewing this decision, the Secretary was to give the appropriate State health planning and development agency (referred to as the State Agency) opportunity to consider the decision and submit its comments to the Secretary. After taking these comments (if any) into consideration, the Secretary could decide to make the Federal funds in question available for the proposed use. Each decision to make funds available despite an agency's disapproval was to be submitted to the agency and the State Agency together with a detailed statement of the reasons for the decision.

Each health systems agency was required to review and make recommendations to the State Agency respecting the need for new institutional health services. These findings were to be used by the State Agency in making findings as to the need for such services.

At least every five years, each health systems agency was required to review all existing institutional health services and make recommendations to the State Agency respecting the appropriateness in the area of such services. After consideration of these recommendations,

and a review of all existing institutional health services in the State, the State Agency was to publicize its findings. The initial review by the health systems agency was to be completed wthin 3 years of its full designation.

Each health systems agency was required to recommend annually to the State Agency projects, and priorities among them for the modernization, construction, and conversion of medical facilities in the area designed to achieve the agency's HSP and AIP (sec. 1513).

ASSISTANCE TO ENTITIES DESIRING TO BE DESIGNATED AS HEALTH SYSTEMS AGENCIES

The Act authorized the Secretary to provide necessary technical and other nonfinancial assistance to nonprofit private entities which had the potential to become health systems agencies. Such assistance was to include prototype plans of organization and operation. Entities eligible for assistance included existing CHP and RMP agencies (sec. 1514).

DESIGNATION OF HEALTH SYSTEMS AGENCIES

The Act required the Secretary to enter into agreements for the designation of health systems agencies at the earliest date practicable after establishment of health service areas but no later than July 1976. In considering applications for conditional or full designation, the Secretary was required to give priority to applications recommended for approval by existing areawide CHP agencies or RMPs in the area.

The Secretary could initially enter into a conditional designation agreement (not to exceed 2 years) with eligible entities. Prior to entering a conditional designation agreement, the Secretary was required to consult with the Governor of each State in which the health service area was located and with other appropriate State and local officials.

During the period of conditional designation, the Secretary could require that the HSA meet only certain organizational and operational requirements and perform only certain limited functions. The number and type of requirements and functions would be progressively increased, so that by the end of the period, the entity could be considered for full designation.

The Secretary could enter into a full designation agreement with an entity once he determined it to be capable of fulfilling the full range of requirements and functions. The Governor of each State was to be consulted regarding the proposed final designation of an HSA in his State. The duration of a full designation agreement was one year. The agreement could be renewed if the agency was performing its functions satisfactorily and continued to meet the organizational and operational requirements.

Conditional designation agreements could be terminated upon 90 days' notice by either the Secretary or the HSA. Full designation agreements could be terminated at such time and upon such notice by either party, as prescribed by regulations, except that the Secretary could only terminate such agreements if the agency was not carrying out the provisions of the designation agreement (sec. 1515).

PLANNING GRANTS

Each agency was to receive planning grants for compensation of personnel, data collection, planning, and performance of required functions. Planning grant funds could also be used to assist the HSA in performance of its functions but could not be used for the development of health resources or delivery of health services.

The amount of any grant to a conditionally designated health systems agency was to be determined by the Secretary. The amount of a grant to an agency under full designation was to be based on a rate of 50 cents per capital, up to $3.75 million. In addition, the Secretary was authorized to match locally generated funds up to 25 cents per capita. An agency could not accept funds for matching purposes from any individual or private entity having a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources nor could such contributions have conditions attached to their use. The minimum planning grant for a health systems agency under either a conditional or full designation agreement was set at $175,000.

If the total amount of grants to be made exceeded the total amount actually appropriated for planning grants for a particular fiscal year, the amount for each health systems agency was to be proportionately reduced. Under these conditions, no agency could receive less than $175,000 unless enough money had not been appropriated to make even this minimum level grant to each agency.

The law authorized $60 million in fiscal year 1975, $90 million in fiscal year 1976, and $125 million in fiscal year 1977 (sec. 1516).

DESIGNATION OF STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

Public Law 93–641 provided for the establishment in each State of a State health planning and development agency (State Agency) selected by the Governor and designated by the Secretary. Prior to designation of the State Agency, each State was to submit to the Secretary an approved State administrative program containing assurances satisfactory to the Secretary that the Agency selected by the Governor had the authority and resources to administer the State's administrative program and to conduct the requisite health planning and developmental functions.

The Secretary could initially enter into a conditional designation agreement (for a period not to exceed 2 years) with the Governor of a State. Such agreement had to include a plan, submitted by the Governor, for the orderly assumption of required functions. During the period of conditional designation, the State Agency could be required to perform only those functions the Secretary deemed it capable of performing. The number and type of usch functions would be progressively increased so that by the end of the period the State Agency could be considered for full designation.

The Secretary could enter a final designation agreement with a Governor, if he determined the agency to be capable of fulfilling the full range of required responsibilities.

A full designation agreement was to be for a one year period. It could be renewed if the State Agency was fulfilling its responsibilities

in a satisfactory manner and if the State administrative program continued to meet specified requirements.

Conditional designation agreements could be terminated upon ninety days' notice by either the Secretary or the State Agency. Full designation agreements could be terminated at such time and upon such notice by either party as prescribed by regulations, except that the Secretary could only terminate such agreements if the State Agency was not complying with or effectively carrying out the terms of the agreement. If a conditional or final designation agreement was terminated prior to its expiration, the Secretary could, in accordance with the requisite procedures, enter into another agreement with the Governor for designation of a State Agency.

If a designation agreement was not in effect by October 1, 1980, the Secretary could withhold Federal funds (in the form of grants, loans, loan guarantees, or contracts) under the PHS Act, the Community Mental Health Centers Act, or the Alcoholism Act for the development, expansion, or support of health resources until such time as an agreement was in effect (sec. 1521).

STATE ADMINISTRATIVE PROGRAM

The Secretary could not enter into a designation agreement with the Governor of a State until the Governor submitted and the Secretary approved a State administrative program for the performance by the State agency of the functions prescribed under section 1523. Prior to submission, the Governor was to afford the general public reasonable opportunity for a presentation of views.

The law required the State to meet a number of requirements designed to assure the effective administration of the program, and the Secretary was required to approve any State program which met these requirements. He was further required to conduct annual reviews of the operations of the State Program (sec. 1522).

STATE HEALTH PLANNING AND DEVELOPMENT FUNCTIONS

The law set forth the following functions to be performed by the State health planning and development agency (or its designee, in cases where these functions had been delegated upon request of the Governor to another State Agency under an agreement satisfactory to the secretary):

(1) conduct the health planning activities of the State and seek to impelment appropriate parts of the State health plan (prepared by the Statewide Health Coordinating Council (SHCC)) and the plans of the HSAs;

(2) prepare and revise as necessary, but at least annually, a preliminary State health plan which would be made up of the HSP's of the health systems agencies. The preliminary State health plan was to be submitted to the SHCC for its use in preparing the State health plan;

(3) assist the SHCC in review of the State medical facilities plan required under the new title XVI, and in the performance of its functions generally;

(4) serve as the designated planning agency of the State for the purposes of section 1122 of the Social Security Act in those

States which participate in the 1122 program, and administer the State certificate of need program which would apply to new institutional services proposed to be offered or developed in the State;

(5) make findings as to the need for new institutional services proposed to be offered in the State after consideration of recommendations made by HSAs; and

(6) review on a periodic basis (at least every five years) existing institutional health services, and after consideration of recommendations made by HSAs, make findings public. The review had to be completed within one year after receiving recommendations from a health systems agency.

The mandatory certificate of need program (which had to be satisfactory to the Secretary) was to provide for review and determination of need prior to the time services, facilities, and organizations were offered or developed or substantial expenditures undertaken in preparation for such offering or development. The program was to assure that only those services found to be needed would actually be offered or developed. In administering the State's certificate of need program and serving as the section 1122 planning agency, the State Agency was to consider recommendations of the health systems agencies.

If a State Agency were to make a decision in carrying out its review functions which was inconsistent with the recommendation of a health system agency, it was required to submit a detailed statement to such agency (sec. 1523).

STATEWIDE HEALTH COORDINATING COUNCIL

The law provided that each State health planning and development agency would be advised by a Statewide Health Coordinating Council (SHCC). The SHCC was to be comprised of at least 16 representatives appointed by the Governor from lists of at least five nominees submitted by each health systems agency falling in whole or in part within the State. Each Agency was entitled to at least two representatives, and each agency was to be equally represented. At least half of the representatives of each HSA were required to be consumer representatives. The Governor could appoint additional representatives (at least half of whom were consumers) who could constitute up to 40 percent of the total membership. At least one-third of the provider members had to be direct providers of health care. An appointee of the Veterans' Administration was to serve as an ex officio member in States with two or more VA facilities. The SHCC was required to select its own Chairman, hold all business meetings in public and meet at least four times a year.

The SHCC was directed to review annually and coordinate the HSP and AIP of each health systems agency and report its comments to the Secretary for purposes of his review of the budgets and performance of health systems agencies under section 1535. The SHCC was also directed to prepare and review, and revise as necessary (but at least annually), the State health plan, using the preliminary plan prepared by the State Agency as a draft. The SHCC was to conduct a public hearing on this proposal and subsequently prepared the final plan including any necessary revisions to the HSP's of the health systems agencies. Each health systems agency was required to make

available its HSP for integration into the State health plan and to revise such HSP as required.

The SHCC was to review the budget of each health systems agency within the State annually, review applications by HSAs for planning and development funds, and forward its comments to the Secretary.

In addition, the SHCC was required to advise the State Agency on the performance of its functions and annually review and approve or disapprove any State plan and any application submitted to the Secretary as a condition for receipt of any funds under allotments made to States under the PHS Act, the Community Mental Health Centers Act, and the Alcoholism Act.

If a SHCC were to disapprove an application for Federal funds, the Secretary could not make such funds available until upon request of the Governor of the State, he completed a review of the SHCC recommendations. If following his review, the Secretary approved the application, he was to submit a detailed statement of his reasons to the SHCC (sec. 1524).

GRANTS FOR STATE HEALTH PLANNING AND DEVELOPMENT

Each designated State Agency was to receive a grant from the Secretary to assist it in meeting for up to 75 percent of its costs of operation during the period for which the grant was available for obligation. The State Agency was required to expend, in the performance of its prescribed functions, an amount from non-Federal sources equal to the average amount spent by the State in the preceding three years for similar purposes.

The bill authorized $25 million in fiscal year 1975, $30 million in fiscal year 1976, and $35 million in fiscal year 1977 (sec. 1525).

GRANTS FOR RATE REGULATION

The law established a demonstration program to determine the effectiveness of rate regulation. Up to six State Agencies under a final designation agreement could receive grants if they were currently regulating rates or had indicated their intent to regulate rates prior to July 4, 1975. State Agencies receiving assistance were required to provide the Secretary with a current budget, set forth personnel criteria, have a rate regulation staff headed by a Director, provide for necessary methods of administration and perform functions in accord with procedures established which they had and published. The State Agency was to establish a procedure whereby it would obtain the recommendation of the appropriate health systems agency prior to conducting a rate review.

The Secretary, in prescribing requirements for State Agencies, was required to consider whether the Agencies should: (1) permit providers to retain savings accruing from effective management; (2) create incentives for economical utilization of services; (3) document the need for and cost implications of new services; and (4) employ for each class or type of provider a unit for determining reimbursement rates and a base for determining rates of change of such rates.

Grants for rate regulation were to be made on such terms and conditions as the Secretary prescribed. A grant was to be made for a one

year period with a maximum of three such grants awarded to a single State Agency.

Each State Agency receiving a grant was required to make an annual report to the Secretary. The Secretary was then to report annually to Congress on the effectiveness of rate regulation.

The bill authorized $4 million for fiscal year 1975, $5 million for fiscal year 1976, and $6 million for fiscal year 1977 (sec. 1526).

GENERAL PROVISIONS: DEFINITIONS

This section of the law set forth definitions of terms as they applied to the program established by title XV. Included were definitions of "State," "Governor," "provider of health care" (including both direct and indirect providers as noted earlier in section 1512), "health resources," and "institutional health services." It should be noted that the last term "institutional health services," was defined as services provided through both health care facilities and health maintenance organizations (sec. 1531).

PROCEDURES AND CRITERIA FOR REVIEWS OF PROPOSED HEALTH SYSTEM CHANGES

In reviewing proposed uses of Federal funds or the need for proposed or existing health services, each health systems agency (and each State Agency in performing its mandated review functions) was required to follow procedures and apply criteria developed and published by it in accordance with regulations issued by the Secretary. Such procedures and criteria could vary according to the purpose for which the review was conducted or the type of service being reviewed.

The law specified the procedural activities which must be performed during reviews and enumerated a number of substantive considerations which were to be taken into account. Among the various procedural stipulations were the following requirements: advance written notification to affected persons, a 90-day maximum review period, provision for written findings on decisions, notification of providers and others of findings made in the course of review, provision for public hearings if requested by affected parties, public access to all written materials pertinent to review, and letters of intent to be submitted by entities proposing projects detailing the scope and nature of projects.

Criteria for review were to include consideration of at least the following: relationship of health services under review to the applicable HSP and AIP; long-range development, the existing health care system, and the plan of the person providing or proposing such services; the need of the population for such services; availability of less costly or more effective alternatives; availability of resources; special needs and circumstances of entities providing a substantial portion of their services or resources to individuals not residing in the health service area (such as health professions schools, multidisciplinary clinics, specialty centers, etc.); special needs and circumstances of health maintenance organizations; and for construction projects, the costs and methods of proposed construction and probable impact on costs of providing health services (sec. 1532).

TECHNICAL ASSISTANCE FOR HEALTH SYSTEMS AGENCIES AND STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

The Secretary was required to provide (directly or through grants or contracts) technical assistance to health systems agencies and State Agencies. Such assistance was to include specification of minimum data needs; planning approaches, policies and standards consistent with the national guidelines for health planning and covering specified national health priorities; and guidelines for organization and operation of the health systems agencies and State Agencies.

The Secretary was directed to establish a national health planning information center (NHPIC) to support a health planning and resources development programs and to provide information.

The Secretary was to establish the following prior to January 4, 1976: a uniform system for calculating the aggregate cost of operation and the aggregate volume of services provided by health service institutions; a uniform system for cost accounting and calculating the volume of such services; a uniform system for calculating rates to be charged to health insurers and other health instituions payors by health service institutions; a classification system for health services institutions; and a uniform system of reporting costs, volume of services, and rates of such institutions (sec. 1533).

CENTERS FOR HEALTH PLANNING

The law provided authority for the creation of regional centers for health planning to provide technical and consulting assistance to HSAs and State Agencies. The Secretary was to make grants or contracts to public or private nonprofit entities to meet the costs of planning and developing such centers. To the extent practicable, at least five centers were to be in operation by June 30, 1976. Centers were required to have a full-time director knowledgeable in health planning and resources development and additional professional staff representing a diversity of relevant disciplines. Centers could arrange with HSA's and State Agencies to provide necessary services and were required to disseminate to them the planning approaches, methodologies, policies, and standards they developed.

The law authorized $5 million for fiscal year 1975, $8 million for fiscal year 1976, and $10 million for fiscal year 1977 (sec. 1534).

REVIEW BY THE SECRETARY

The law required the Secretary to review and approve or disapprove (after considering of the comments of the SHCC) the annual budget of each designated health systems agency.

The Secretary was directed to establish performance standards covering the structure, operation, and performance of required functions of each health systems agency and each State Agency. A reporting system based on these performance standards was mandated to allow for continuous review. At least every three years, the Secretary was to review in detail the structure, operation, and performance of each HSA and each State Agency. The review was to include a determination of whether the requirements of law had been met; the adequacy of the appropriate health plan; the professional credentials and com-

petence of the staff; and the extent to which improvements had been made in health status and health delivery and the extent to which cost increases had been restrained. The review of a health systems agency was also to include a determination of the representative character of the governing body, the appropriateness of data assembled and quality of its analysis, and extent to which technical and financial assistance provided the agency had been utilized in an effective manner. The review of State Agency operations was also to include a performance review of the SHCC and a determination of the extent to which financial assistance provided under the new health resources development program (title XVI) had been used effectively to achieve the State's health plan (sec. 1535).

SPECIAL PROVISIONS FOR CERTAIN STATES AND TERRITORIES

Any State which had successfully operated a statewide health planning system which substantially complied with the purposes of the Act and which had no county or municipal public health institutions or departments could apply for a waiver from the requirements to establish health service areas and health systems agencies. The State Agency could perform the prescribed functions and be eligible for planning and development grants. The Governor was to appoint the members of the SHCC in accordance with regulations issued by the Secretary.

The statute specifically provided for the inclusion of the Virgin Islands, Guam, the Trust Territories in the Pacific Islands, and American Samoa under this provision (sec. 1536).

HEALTH RESOURCES DEVELOPMENT: PURPOSE

Public Law 93–641 added a new title XVI, "Health Resources Development" to the Public Health Service Act. The new title provided Federal assistance for construction and modernization projects for specified purposes and authorizes grants to health systems agencies for establishment and maintenance of Area Health Services Development Funds.

Federal assistance through allotments, loans, and loan guarantees (including interest subsidies) was provided for projects for: (1) modernization of medical facilities; (2) construction of new outpatient medical facilities; (3) construction of new inpatient medical facilities in areas (as determined under the Secretary's regulations) which had experienced recent rapid population growth; and (4) conversion of existing medical facilities for the provision of new health services.

In addition, the measure authorized special project grants for projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards (sec. 1601).

GENERAL REGULATIONS

The Secretary was required to issue regulations prescribing the general manner in which the State Agency would set priorities, among projects based on the relative needs of different areas and special

considerations defined in law. He was also required to prescribe: (1) general standards of construction, modernization, and equipment; (2) criteria for determining the need for facilities and beds and needs for modernization of facilities; (3) requirements that each State medical facilities plan provide adequate medical facilities for all State residents and facilities for the provision of services to persons unable to pay therefor; and (4) the general manner in which an entity receiving assistance would be required to comply with required assurances and demonstrate compliance.

Such entities were required to submit periodically to the Secretary data and information which reasonably supported the entity's compliance (sec. 1602).

STATE MEDICAL FACILITIES PLAN

Before any application for Federal assistance under title XVI (except for special project grants) could be approved, the State Agency would have to submit (and have approved by the Secretary) a State medical facilities plan which had been reviewed and approved by the SHCC. It was to set forth an assessment of need for inpatient and outpatient services and facilities and need for modernization or conversion of existing facilities, based on a State-wide inventory of existing facilities, a survey of need, and plans of health system agencies; a program of assistance indicating type of assistance which should be provided each project, and priorities among those projects. The Secretary was required to approve the plan if: (1) it contained the items prescribed by law; and (2) the State Agency (as determined by his review) was organized and operated and performing the functions prescribed under title XV.

The State Agency was entitled to a hearing if any plan or modification thereof was disapproved by the Secretary for failure to comply with the requirements of law (sec. 1603).

APPROVAL OF PROJECTS

Receipt of Federal project assistance was contingent upon submission of an application to the Secretary through the State Agency. The applicant could be a State, political subdivision of a State or other public entity, a nonprofit private entity, or a combination of such entities. Applications for special project grants were to be submitted directly to the Secretary by a State or political subdivision of a State. Each application was to be reviewed by the appropriate health systems agency in accordance with requirements for review of proposed use of Federal funds.

Among the items to be included in the application were the following: a finding of need by the State Agency, description of the project site, reasonable assurance that adequate financial support would be available for project completion and subsequent operation, certification of the Federal share for the project (except for special project grants), and assurances regarding compliance with labor standards. Applications for construction or modernization of an outpatient facility were to contain assurances that general hospital services will be available for patients requiring such care. All applications were also

to provide reasonable assurances that: (1) the facility or portion thereof receiving assistance would be available to all persons residing or employed in the area ,and (2) there would be made available in such facility or portion thereof a reasonable volume of services (as determined by the Secretary taking into consideration financial feasibility) for persons unable to pay for them.

The law included special provisions in the case of an application for a modernization project for an outpatient facility which would provide general purpose health services, which was not part of a hospital, which would serve a medically undeserved population, and for which not more than $20,000 was sought for allotments or loans. For such projects the Secretary could waive requirements respecting modernization and equipment standards and title to project site.

The Secretary was required to approve a project application for allotments or loans or loan guarantees if the application was conformed with the State medical facilities plan, had been recommended and approved by the State Agency, was entitled to priority over other projects in the State (as determined in accordance with the medical facilities plan) and contained the necessary assurances.

No project application for an allotment, loan or a loan guarantee could be disapproved until the State Agency had been afforded an opportunity for a hearing (sec. 1604).

ALLOTMENTS

Allotments among the States for project money were to be made by the Secretary each fiscal year on the basis of population, financial need, and need for medical facilities projects of the respective States. The minimum allotment for any State was set at $1 million, except that the minimum allotment for Guam, American Samoa, the Virgin Islands and the Trust Territory of the Pacific Islands was to be $500,000. If the total amount appropriated in any fiscal year was insufficient to make the specified minimum allotments, the amount for all States would be proportionately reduced. Allotments were to remain available for obligation for three fiscal years except that the Secretary was authorized to reallot unobligated allotments to other States at the end of the second fiscal year after the allotment was made. Such reallotment monies were to be in addition to amounts allotted to the State during the period (sec. 1610).

PAYMENTS FROM ALLOTMENTS

The Secretary was required to make payments to a State from its applicable allotment for any approved project if the State Agency certified (on the basis of its inspection) that in accordance with approved plans and specifications, work had been performed or purchases made and that payment was due.

If an amendment to an application was approved or the cost estimate was revised upward, additional payments could be made from the State's allotment. In no case could the total payments under allotments exceed the Federal share (generally not to exceed two-thirds of project costs) for the project. No more than twenty percent of a State's allotment could be obligated for construction of new in-

patient facilities. Not less than 25 percent of such allotment could be used for outpatient facilities which would serve medically underserved areas; the Secretary was to seek to assure that these funds were equally divided between urban and rural areas (sec. 1611).

WITHHOLDING OF PAYMENTS AND OTHER COMPLIANCE ACTIONS

The Secretary was authorized (after reasonable notice and opportunity for a hearing to the State Agency) to withhold payments under allotments if he found that: (1) the State Agency was not in substantial compliance with items required to be included in the State medical facilities plan; (2) requisite assurance for an application was not or could not be carried out; (3) there was substantial failure to carry out the project plans and specifications. Under these circumstances he could withhold payments in whole or in part from specific projects or all projects in the State for which the finding was made.

The Secretary was periodically required to ascertain compliance by each entity receiving assistance. If he found an entity out of compliance, he could withhold funds or take other actions authorized by law which would effect compliance. A compliance action could be brought by a person other than the Secretary only if the Secretary had dismissed the complaint or the Attorney General had not taken action within 6 months after the complaint was filed (sec. 1612).

AUTHORIZATION OF APPROPRIATIONS

Public Law 93–641 authorized appropriations for allotments of $125 million in fiscal year 1975, $130 million in fiscal year 1976, and $135 million in fiscal year 1977. Twenty-two percent of appropriated funds were earmarked for project grants authorized under Section 1625 (sec. 1613).

AUTHORITY FOR LOANS AND LOAN GUARANTEES

The Secretary was authorized for each of fiscal years 1975, 1976, and 1977 to make loans to pay the Federal share (generally not to exceed 90 percent) of the cost of approved projects and to guarantee loans made by non-Federal lenders or the Federal Financing Bank to nonprofit private entities for such projects. In the case of a guaranteed loan, the Secretary was to pay interest subsidies in an amount sufficient to reduce the effective annual interest rate by three percentage points. The cumulative total of principal on outstanding guaranteed loans could not exceed limitations specified in appropriation Acts. The Secretary, with the consent of the Secretary of the Department of Housing and Urban Development (HUD), was to obtain such assistance from HUD as needed to administer the program (sec. 1620).

ALLOCATION AMONG THE STATES

For each fiscal year, the total amount of principal of guaranteed and direct loans was to be allocated by the Secretary among the States (in accordance with regulations) on the basis of population, financial need and need for medical facilities. Allotments to States were to remain available for obligation for three fiscal years; if the Secretary

determined at the close of the second year that an amount would not be obligated during the period, he could reallot such amounts among the States (sec. 1621).

GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

The law enumerated requirements including general financing arrangements and conditions applicable for loans and loan guarantees. Loan guarantees could not be made if the interest rate exceeded the prevailing rate or if the loan would otherwise be available on reasonable terms and conditions. Direct loans could not be made unless the Secretary was reasonably satisfied that the applicant would be able to meet the payments and obtain additional funds necessary to complete the project. The interest rate on such direct loans was to be the current prevailing interest rate minus three percentage points.

The Act established a loan and loan guarantee fund in the Treasury and authorized appropriations from time to time of such amounts as would be necessary to provide sums required for the fund. To provide additional capitalization for the fund, the law authorized appropriations to the fund of such sums as would be necessary for the fiscal years 1975, 1976, and 1977 (sec. 1622).

PROJECT GRANTS

The Secretary was authorized to make grants for construction or modernization projects designed to: (1) eliminate or prevent imminent safety hazards as defined by Federal, State or local fire, building or life safety codes or regulations; or (2) avoid noncompliance with State or voluntary licensure or accreditation standards.

Project grants could be made only to a State or political subdivision (including any city, town, county, borough, hospital district authority, or public or quasi-public corporation) for a project for a medical facility owned or operated by it. Grant applications were to contain assurances that the applicant would not otherwise be able to complete the project.

The amount of any grant could not exceed 75 percent of total project cost except in urban or rural poverty areas where the grant could cover up to 100 percent of the cost. The Act required that 22 percent of the funds appropriated for allotments under section 1613 would be earmarked for such project grants (sec. 1625).

JUDICIAL REVIEW

The law provided for appeal in the appropriate U.S. court of appeals by a State health planning and development agency in the case of a disapproved project application, or by a State dissatisfied with, or an entity which would be adversely affected by, the Secretary's decision to withhold payments or take other compliance action (sec. 1630).

RECOVERY

The law provided for the recovery by the U.S. of its proportionate share of current value of any facility receiving assistance under this program, if at any time within 20 years after completion of construction, modernization or conversion, the facility was sold or transferred

to any person or entity not qualified to be an applicant under the program or not approved by the State Agency as a transferee; or the facility ceased to be a medical facility unless the Secretary determined there was good cause for such termination.

The Secretary could waive recovery rights under certain conditions (sec. 1631).

STATE CONTROL OF OPERATIONS

The law prohibited Federal employees from exercising any supervision or control over the administration, personnel, maintenance, or operation of any facility assisted under the program (sec. 1632).

DEFINITIONS

The law defined terms used under title XVI (sec. 1633).

FINANCIAL STATEMENTS; RECORDS AND AUDIT

Entities assisted under the program were required to keep records and file annual statements respecting the financial operations of the facility and the costs to the facility and charges made by the facility for the provision of health services with the Secretary. The Secretary and Comptroller General were permitted access to records for the purpose of audit. Entities receiving assistance (other than project grants) were further required to file a similar statement with the relevant State Agency (sec. 1634).

TECHNICAL ASSISTANCE

The Secretary was required to provide technical and other nonfinancial assistance to entities necessary to assist them in developing applications for assistance. He was also to make every effort to inform eligible applicants of the availability of such assistance (sec. 1635).

DEVELOPMENT GRANTS FOR AREA HEALTH SERVICES DEVELOPMENT FUNDS

The Secretary was required to make an area health services development grant in each fiscal year to each health systems agency which: (1) had in effect a full designation agreement; (2) had in effect an HSP and AIP reviewed by the SHCC; and (3) was organized and operated in the prescribed manner and performing its required functions.

This grant was to enable the agency to establish an Area Health Service Development Fund from which it could make grants and contracts for projects to achieve the health system described in the HSP.

The amount of the development grant (up to a maximum of $1 per capita of the area) was to be determined by the Secretary after taking into consideration the area's population, family income, and supply of health services. No grant could be made to an agency unless it had submitted an approved application.

The law authorized $25 million for fiscal year 1975, $75 million for fiscal year 1976 and $120 million for fiscal year 1977 (sec. 1640).

RECENT LEGISLATIVE HISTORY

The original authorities for titles XV and XVI of the Public Health Service Act as provided by Public Law 93–641 were due to expire at the end of fiscal year 1977. Because the Congressional budget process required that Committee consideration of legislation providing budgetary authorizations for fiscal year 1978 be completed by May 15, 1977, was not afforded the new administration sufficient time to review the planning law and programs and prepare their own policy positions and proposals with respect to it. Thus, a one year simple extension was enacted (Public Law 95–83) to permit HEW an opportunity to conduct a thorough review of these programs and to permit Congress with an opportunity to review the program in anticipation of substantive consideration of the law prior to the May 15, 1978 reporting deadline.

Aside from the one-year extension of authorizations provided under Public Law 95–83, no significant amendments have been made to the health planning and resources development program since its enactment in 1974. However, action was taken by Congress to enable HEW to extend conditional designation agreements for health systems agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) from the 24 month period specified in Public Law 93–641 to a period of up to 36 months. These provisions were contained in amendments to the Health Professions Education Amendments of 1977 (Public Law 95–215).

During the first 24 months of conditional designation, only a handful of HSAs and SHPDAs had been able to comply with requirements for full designation. It was recognized that, without the provisions contained in Public Law 95–215, conditional designation agreements for most of the existing HSAs and SHPDAs would have expired before Congress could take up consideration of substantive changes in the law. To avoid disrupting the efforts which had been made toward developing the health planning systems, the committee felt that a 12-month extension in conditional designation agreements was warranted if the Secretary determined that unusual circumstances had prevented a health planning entities from qualifying for full designation. The committee stipulated, however, that this amendment was not to be used simply to allow a marginal HSA another year of funding. The Secretary was directed to determine that the additional year would in all likelihood enable the HSA to qualify for full designation.

Action was also taken by the Congress to amend certain sections of Title XV as part of the National Energy Conservation Policy Act, Public Law 95–619. These amendments made by that Act are as follows. First, section 1502 of the Public Health Service Act was amended by adding an eleventh priority: "the promotion of an effective energy conservation and fuel efficiency program for the health service institutions to reduce the rate of growth of demand for energy". Second, section 1532(b)(2) was amended to provide that the period for project reviews in the case of non-substantive reviews take less than 90 days. Finally, section 1532(c) was amended to provide that health planning agencies in adopting criteria for review of construction projects, con-

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sider the costs and methods of energy provision. It also added a tenth criteria for health planning agency consideration. It provided that "the special circumstances of health service institutions and the need for conserving energy" should be considered in the review of applications by the health planning agency.

VI. Progress in the Implementation of Public Law 93–641

As noted earlier in the report, Public Law 93–641 instituted the development of a major new system of institutions responsible for planning the Nation's health care system. In the intervening years, progress has been made in the development of this system. The Committee feels that the basic structure put in place by Public Law 93–641 is sound, although, implementation of the law has not been without problems of controversy. The following discussion makes brief mention of the relevant sections of the law described earlier in the report and reviews some of the progress which has been made and the issues which have arisen since enactment.

NATIONAL GUIDELINES FOR HEALTH PLANNING

Section 1501 of the Act requires the Secretary to issue National Guidelines, by regulation, concerning national health planning policy. The purpose of the guidelines is to help clarify and coordinate national health policy and to assist HSAs in developing required health systems plans. An agency is to examine the relationship between its area's experience and the national goals and standards and reflect the national priorities in the area's health plans. Agencies will, of course, also deal with important local problems which are not addressed in the national guidelines.

As noted in the conference report (H. Rept. 95–500) which accompanied the one year extension of the Act (Public Law 95–83), considerable delay had been experienced in issuing the guidelines, which were to have been published by July 4, 1976. The committee urged that early and aggressive efforts on the part of the new administration be taken to complete the necessary work on the guidelines.

On September 23, 1977, the Secretary published a notice of proposed rulemaking proposing an initial set of national guidelines pertaining to general hospital beds; obstetrical, pediatric, and neonatal special care units; open heart surgery and cardiac catheterization units; radiation therapy; computed tomographic scanners; and end-stage renal disease. In publishing the initial set of guidelines, the Department chose to focus on a limited number of issues of relating to hospital resources that were felt to present important short-term opportunities for the containment of costs and the enhancement of the quality of care. The Department noted that this initial set of guidelines represented the first segment of what was to become a rational, comprehensive set of health planning goals and standards, addressing such issues as cost containment, access to care, availability and distribution of health care resources, quality of care and health status. The Department noted that regulations respecting areas not addressed in the initial set of guidelines would be proposed in the near future.

During the public comment period on the proposed guidelines, more than 55,000 communications were received by the Department. By and large, those comments were highly critical of both the substance of the guidelines and the process by which they had been developed. Dissatisfaction focused primarily on the following areas: (1) degree of local control over health planning decisions, (2) potential impact on rural areas with many small community facilities, (3) scope and emphasis of the guidelines, (4) the unintentional impetus given to unnecessary utilization, (5) premature issuance without sufficient outside consultation, (6) confusion over the role of HSAs in closure of noncomplaint facilities, (7) potential for impairment of educational programs conducted by certain institutions, and (8) failure to address the question of services provided through Federal health care facilities

Public response to the initial guidelines was overwhelming. Some congressional offices reported receiving as many as 10,000 to 12,000 letters. At oversight hearings held in October 19, 1977, several members of this committee expressed their concerns to Departmental spokesmen. On November 30, HEW Secretary Califano responded by sending a letter to Members of Congress clarifying the intent of the proposed guidelines and responding to issues raised in the public comments. Among other things he noted that neither the Act nor the guidelines authorized an HSA or State Agency, or the Secretary to close existing hospitals or hospital services. He agreed to clarify and broaden the exceptions applicable to rural and community facilities and the standards proposed for obstetrical units. He also emphasized that nothing in the Act or the guidelines was intended to take health planning decisions concerning individual facilities out of local and State hands.

On December 6, 1977, the House unanimously passed a resolution asking the Department to allow areas with rural hospitals to deviate from the guidelines. A letter to HEW Secretary Califano signed by about half the Members of the Senate contained a similar message.

In December 1978, a series of five public meetings were held by the Department, during which individuals from the fields of medicine, health administration, and consumer interest were actively consulted. Comments and recommendations were also solicited from all State and local health planning agencies and numerous professional and consumer groups. Efforts were made to document sources of material used in developing the standards, such as material obtained from the Institute of Medicine, the Office of Technology Assesment, and many national professional associations and other organizations involved in setting standards for medical care.

Finally, on January 20, 1978, a revised version of the guidelines was published as a notice of proposed rulemaking. In view of the widespread interest in this material, the Secretary had decided it would be desirable to provide an additional 30-day period for public review and comment prior to publication of the guidelines as final regulations. On March 28, 1978, final regulations on the national guidelines (substantially the same as those published on January 20) were published by the Secretary. The revised standards left intact the requirements for a hospital bed ratio of four beds per 1,000 population and a minimum average annual hospital occupancy rate of 80 percent within a health service area. However, the revised guidelines contained a num-

ber of revisions to take further account of the special conditions and needs of rural areas, and emphasized the responsibility of HSAs to make adjustments in their plans and reviews to take these into account. The new draft relaxed the numerical standards for rural and small-town hospitals by broadening the exceptions which could be considered by HSAs when applying standards. In particular, the revised guidelines permitted deviations from the bed ratio and occupancy standards if distance to sources of hospital care exceeded a traveltime factor of 30 minutes (the original standards had set 45 minutes) and if the area's elderly population exceeded 20 percent of the national average (33 percent in the September 23rd proposals).

Standards in a number of other areas were eased, in particular those pertaining to obstetrical services and CAT scanners. The earlier figures for obstetrical services had called for 2,000 deliveries annually in a metrcpolitan area and at least 500 in rural areas. The revised guidelines dropped all mention of numerical standards for deliveries annually, except for hospitals providing care for complicated obstetrical problems (such hospitals were required to have at least 1,500 deliveries per year). The new draft did retain its earlier figure for average annual occupancy rates of at least 75 percent in each obstetrical unit with more than 1,000 births per year.

Numerical standards for computerized axial tomography (CAT) scanners were changed significantly from a previous level of 4,000 scan procedures annually to a level of at least 2,500 "medically necessary" procedures. The number of scans required before another unit could be approved for acquisition remained, however, at 2,500.

While stopping short of an outright exemption for small rural hospitals (which had felt threatened with imminent closure if application of the standards had been too rigidly imposed by HSAs), the guidelines now permit an upward or downward adjustment to meet a specific local situation. The revised guidelines reemphasize the important responsibility which HSAs have to analyze and plan how the guidelines apply to local needs and conditions.

The standard that has caused the most concern is the one calling for no more than 4.0 short-stay hospital beds per thousand people in each health service area. The Department of HEW has indicated that, over the longer term, HSAs are expected to build into their plans an effort to reach a bed/population ratio of 3.7 beds per thousand population. Presently, half the States have more than 4.5 beds per thousand while 12 States have between 4.0 and 4.5 beds. With regard to the more than 200 HSAs, 95 currently have more than 4.5 beds per thousand and 55 have between 4.0 and 4.5. Some 66 HASs have less than 4.0 beds per thousand.

Using the national guidelines as a basis, the Department of HEW has estimated that the national total of excess beds is currently more than 131,000. In the ten most overbedded States—the ones with the largest number of excess beds (not necessarily the ones with the highest bed/population ratio)—there are a total of 83,000 excess beds, or more than 60 percent of all the excess beds in the Nation.

NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

Section 1503 of the Act mandated the creation of a National Council on Health Planning and Development, responsible for advising and making recommendations to the Secretary concerning national guidelines, implementation and administration of the program, and evaluation of new medical technology. Three members of the Council are ex-officio, nonvoting—the Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary of Health of the Department of HEW. The remaining 12 members are appointed by the Secreary of HEW. Council members are representative of providers, consumers, and government, including at least three HSA representatives and three SHCC representatives.

Throughout 1978, the Council met monthly to advise the Secretary on development of, and to make recommendations on, revisions of the national guidelines for health planning. This intensive advisory role is expected to continue until the Department has published guidelines and regulations on standards and goals related to health status, health promotion, health care, and health financing.

According to the Department, the Council's recommendations on revising the national guidelines were immediately considered and incorporated by the staff developing the revised guidelines, the goals and subgoals. Through its public deliberations and the Department's public responses, the Council served as a beacon of hope for HASs, SPHDAs, and provider and consumer groups concerned about the development and impact of the original set of guidelines published September 23, 1978.

The Council is intended to provide a mechanism for coordinated deliberation about and response to HEW policies and proposals affecting the health care system. Its mandate crosses organizational lines within the Department since its composition is a microcosm of the forces that must work together to improve the health care system. The agenda materials prepared for the Council, as well as the minutes, have a wide circulation through direct distribution or through national newsletters. The triple functions of the Council require liaison with other councils advising the Secretary, such as the PSRO Council and the National Health Insurance Council.

The key to the Council's effectiveness is the public discussion, the public consideration of widely different viewpoints, and the public resolution in the form of discussions on what to advise the Secretary on the development of national health policies. Each of the members represents constituencies which, as organizations or individuals, are not shy about pushing their special interests. The Council represents a forum in which these special interest concerns can be brought out in a focused discussion and the Department's responses can be enunciated.

HEALTH SERVICES AREA

To implement the law, the Congress authorized a network of area-wide planning agencies, known as health systems agencies, which together will blanket the Nation. Each agency is responsible for a

health service area of approximately 500,000 to 3 million residents. The designated area is supposed to be a reasonable reflection of a health service or medical trade area with at least one center for the provision of highly specialized services. Wherever possible, standard metropolitan statistical areas (SMSAs) are to be contained in only one health service area, a provision which has resulted in 15 interstate HSAs. The areas were designated by the Governors of each State under Federal guidelines.

The process was completed early in 1975. However, seven area redesignations have been formally requested since the initial establishment of health service areas. Although all seven requests have been approved, two of the requests have been subject to subsequent court action. One, the splitting of the single metropolitan Philadelphia area into three separate areas, was overturned by the Federal courts. The other, realignment of health service area boundaries involving certain Kentucky counties, is currently under a temporary restraining order of the U.S. district court.

There are currently 205 health service areas. This is one more than initially designated in September 1975 and resulted from the division of a large sparsely populated area in Arizona into two areas.

HSA and State boundaries are coterminous in 12 States (Delaware, Idaho, Maine, Mississippi, Montana, New Hampshire, Oklahoma, Puerto Rico, South Dakota, Vermont, West Virginia, and Wyoming); and another two areas are essentially so (New Mexico and Utah). Under a section 1536 some States and territories were granted exemptions from the requirements to create a two-tiered (HSA and State) planning structure. They may combine the HSA and SHPDA functions in the latter agency, and all of the eight eligible States and Territories have chosen to do so. (Those eight so-called 1536 entities include American Samoa, District of Columbia, Guam, Hawaii, Rhode Island, Trust Territory of the Pacific Islands, the Virgin Islands, and the Northern Mariana Islands.) Thus, with the eight section 1536 States, 22 of the local health planning jurisdictions are statewide.

Fifteen of the areas are interstate. One covering the Navajo reservation is tri-State; the others are bi-State. Thirteen encompass interstate standard metropolitan statistical areas (SMSAs). All but 36 of the over 270 SMSA's are included within a single area—25 of the 36 split SMSA's are interstate ones. The 36 split SMSA's were split either by waivers granted by the Secretary or by the granting of section 1536 status (District of Columbia and Rhode Island). Six major metropolitan regions with split SMSAs contain approximately 23 million people or over ten percent of the U.S. population. These regions are Boston, Chicago, San Francisco, Oakland, Washington, D.C., Memphis, and Philadelphia.

The population breakdown of these 205 jurisdictions is as follows:

Under 500,000	50
500,000–999,999	85
1,000,000–1,999,999	49
2,000,000–2,999,999	16
3,000,000 and over	5

In terms of geographical size, health service area 3 in Alaska, which encompasses the northern two-thirds of the State with about 320,000

square miles, is the largest. The smallest is area 3 in New Jersey (Hudson County), covering only 46 square miles.

There is a reasonably high degree of congruity with Professional Standards Review Organization (PSRO) areas. There are 45 instances where health service areas and PSRO areas are identical. In another four instances (e.g., Los Angeles, New York City), the health service areas completely encompass two or more PSRO areas. Conversely, 44 health service areas are wholly contained within single PSRO areas (e.g., Colorado, Nevada). Of the remaining incongruent areas, half involve a difference of only one or two counties.

In only eight States (Alabama, Illinois, Kentucky, Nebraska, Pennsylvania, South Carolina, Virginia, and Wisconsin) did any of the areas officially designated by HEW differ from what their Governors had proposed.

HEALTH SYSTEMS AGENCIES

To carry out the health planning function in each of the health service areas described above, the act provided for designation by the Secretary of a health systems agency (HSA). There are now 203 HSAs designated under the terms of the act. As of May 15, 1979, 181 HSAs had been granted full designation and 22 were operating either under their original conditional designation agreements or special waivers allowing certain agencies additional time to comply with requirements for full designation. One agency, the Puerto Rico HSA, has been nonrenewed and another agency, the HSA for Los Angeles County, has been terminated.

Health systems agencies may be private nonprofit corporations (178), a public regional planning body if it meets special requirements (21), or a single unit of local government (4). More than half of the current agencies were formerly areawide "314(b) agencies," so-called for the section of the Public Health Service Act referring to Comprehensive Health Planning Agencies under an earlier health planning authority.

These agencies must be governed by a governing board, a majority (51–60 percent) of the members of which are consumers, with the remainder of the board representing providers, including physicians (particularly practicing ones), dentists, nurses, and other health professions, health care institutions, insurers, professional schools, and the allied health professions. The statute also requires representation of public officials, residents of nonmetropolitan subareas, and Veterans' Administration and health maintenance organization (HMO) facilities where appropriate.

Consumers account for 54 percent (4,692) of the 8,768 members of HSA governing boards. Women account for 38 percent of the consumer composition of boards. Consumer minority members fill 22 percent of governing board positions. Public officials make up almost 15 percent of the governing board composition, primarily categorized as consumer members. Of the public officials on boards, the vast majority are local officials as compared to State and other officials.

Of all the provider members of HSA boards, more than three-fourths are direct providers (physicians, nurses, health care institution administrators, dentists, health and allied health professionals).

Physicians (including osteopaths) make up 27 percent of the provider category, with dentists and nurses making up 6 and 7 percent respectively of the governing board positions for providers. Representatives of health care institutions fill 37 percent of the provider slots on governing boards, with health care insurers—6 percent, health professional schools—7 percent, and allied health professionals—10 percent.

HSAs have reportedly encountered their most dominant problem in complying with requirements for consumer board members representative of various economic and social (age, sex) groups in their communities. Difficulties have also been experienced in satisfying requirements for membership by representatives of allied health professions and health maintenance organizations (HMOs) among the provider categories.

In terms of size of governing bodies, there is a range from a low of 15 members to a high of 37. About one-half of the HSAs have governing bodies numbering greater than 30 and have therefore established the required executive committees. In addition, some 105 HSAs have established 526 subarea councils (SACs)[1] with a total membership of 15,880. The greatest number of the SACs reflect a geographical base consistent with county boundaries, with State planning districts being the second most frequent base for SACs. The range in number of members in SACs is staggering—from Arizona area one having a subarea council of 15 members to the seventh area in New York with more than 1,800 members on its subarea councils.

Nearly all HSAs have staffs that meet the minimum requirements for full designation. There are an estimated 3,903 staff positions of which sixty-nine percent are professional and thirty-one percent support staff. Estimates of number of staff range from a low of two in Arizona area two to a high of 75 for California area 11 and New York area seven. About half of the agencies have between 11 and 20 staff members.

Practically all agencies have expertise in administration, planning, data collection, and resources development with some small number of agencies having difficulties in recruiting people with expertise in planning and data collection. The salary range for the professionals goes from a low of $4,800 to a high of $42,500. In more than 60 percent of the cases, HSAs have filled the key position of executive director with former CHP people. Salary ranges for the executive director position are from a low of $19,000 to a high of $47,000.

The purposes of the planning agencies are to improve the health of residents of a health service area; increase accessibility, acceptability, continuity and quality of health services provided; restrain increases in the cost of providing health services; and prevent unnecessary duplication of health resources. The agency's ultimate responsibility is the provision of effective health planning for its area and the promotion of the development (within the area) of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency.

To meet these responsibilities, each agency must complete a health systems plan (HSP) which is a statement of long range goals for the

[1] P.L. 93–641 permits an HSA to establish one or more "subarea advisory councils" representing parts of the agency's health service area to advise the governing body of the agency on the performance of its functions.

community. Not only is the plan itself considered an important document for the public statement of a community's goals and objectives, but it serves as the basis on which all proposals for new institutional health services and programs, and applications for Federal funds under a significant number of Federal programs will be reviewed. In addition to the long-range plan, there must be an annual implementation plan (AIP) which has specific objectives for the current year's implementation of the HSP.

Each agency also makes recommendations to the State concerning proposals for new services and capital expenditures, and reviews existing services in terms of their appropriateness. In conducting these activities, agencies are required to coordinate with other federally sponsored initiatives (e.g., professional standards review organizations and the cooperative health statistics system), as well as existing planning activities of State and local agencies.

According to survey data validated in December 1977, HSAs have been devoting one-fourth of their effort to plan development as reflected by the functional budget breakdowns of 143 agencies detailed below.

Function	*Funds (percent)*
Plan development	26
Agency organization and management	18
Plan implementation/Review activities	16
Plan implementation/Resource development	13
Data management and analysis	11
Public involvement and education	11
Coordination activities	5
Total	100

One of the key measures used to evaluate effectiveness of health planning is the degree to which health planning activities have resulted in documented cost savings for the health care system. A survey released February 1979 by the American Health Planning Association reports that health systems agencies and State health planning and development agencies disapproved $2.3 billion of a proposed $10.6 billion in capital investments between August 1976 and August 1978. The survey covers 166, or 81 percent, of the country's 205 HSAs and 27, or 52 percent, of its 57 SHPDAs.

The report shows that planning agencies have saved money not only through certificate-of-need review and reviews required under Section 1122 of the Social Security Act, but also through technical assistance to health care facilities and the influences of their health systems plans and State health plans. For example, the health planning review process has in some cases acted to discourage institutional providers from submitting proposals known to be inconsistent with the health systems plan of the local HSA. In other cases, unofficial contacts between providers and the HSA may elicit negative responses to part or all of a capital expenditure proposal, resulting in withdrawal or modification of certain proposals prior to official submission.

The report notes that if unofficial data—referred to as documentable pre-application "reviews"—are considered, the figure for total cost savings by HSAs and SHPDAs would total $3.4 billion. The report notes that 16,000 hospital beds were unofficially proposed, and 11,500 were requested in official applications. Planning agencies disap-

proved 3,700 beds officially, and 7,900 beds in unofficial reviews are included. Some 49,000 skilled nursing home or intermediate care facilities were also unofficially disapproved—20,000 officially—out of an unofficially proposed 114,000 beds, or 85,000 officially requested. It was estimated that such capital investment denials will save about $10 billion in operating costs in the 1980s.

In fiscal year 1976, the average planning grant for the 201 HSAs designated at the time was $315,191, or a per capita amount of $.37. In fiscal year 1977, the average grant per agency was $78,150, or $.46 per capita. In fiscal year 1978, the average per capita grant reached $.52. It was estimated that for fiscal year 1979, the per capita amount would be $.49. A more detailed breakdown is shown below:

HEALTH SYSTEMS AGENCIES PLANNING GRANTS, FISCAL YEARS 1976–78

	Number of HSA's	Per capita	Average per agency
Fiscal year 1976:			
Less than minimum			
At $145,000	21	$0.65	$145,000
At $160,000	26	.37	160,000
At $175,000	24	.31	175,000
Over minimum	130	.29	399,603
Total	201	.37	315,191
Fiscal year 1977:			
Less than minimum	3	1.69	133,146
At minimum ($175,000)	23	.68	175,000
Over minimum	186	.46	519,655
Total	212	.46	478,150
Fiscal year 1978:			
Less than minimum			
At minimum ($17 ,000)	20	.95	175,000
Over minimum	192	.51	563,971
Total	212	.52	527,275

FISCAL YEAR 1979 (ESTIMATE)

	Number of HSA's	Cost	Population	Per Capita
At minimum ($175,000)	30	$5,250,000	7,082,020	$0.74
Over minimum	183	100,680,000	210,917,980	.46
Total	213	105,930,000	218,000,000	.49

Note: Based on $8,600,000 local contribution.

Source: Bureau of Health Planning, DHEW.

The health planning statutes and regulations issued on the designation and funding of HSAs require that HSAs seek to enter into agreements with professional standards review organizations (among other entities with which HSAs have a responsibility to establish cooperative arrangements). Such agreements between HSAs and PSROs are to provide for sharing of data and technical assistance and to assure that actions taken by PSROs which alter the area's health system will be taken in a manner consistent with the health systems plan and annual implementation plan in effect for the area. According to the American Association of Professional Standards Review Organiza-

tions, 171 of the potential 317 agreements, formerly called memoranda of agreement, had been executed by August 1978.

One of the roadblocks to cooperation among HSAs and PSROs has centered on the issue of confidentiality of data requested of the PSRO. It is expected that with the enactment of the Medicare-Medicaid Antifraud and Abuse Amendments public law 95–142) and the subsequent publication of regulations by the Health Care Financing Administration (January 16, 1978) affecting the sharing of PSRO data and the issue of confidentiality, some of these conflicts will be resolved.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

To assure coordinated State level planning, an agency of State government, chosen by the Governor, is designated to serve as the State health planning and development agency (State Agency or SHPDA). The State Agency must have an administrative program approved by HEW for carrying out its functions. All 57 State Agencies have been conditionally designated. The organizational location of these agencies is as follows:

State health department	29
Health and welfare department	18
Governor's office	3
Independent agency or commission	3
Other agencies	3

These 57 State Agencies currently have staffs totalling 1,551. Seventy-one are professional staff and 29 percent support personnel. Staff size averages 24. Directors' salaries range from a maximum of $45,000 to a minimum of $17,500. Professional staff salaries range from a maximum of $36,936 to a minimum of $6,700.

The State Agency is responsible for conducting the State's health planning activities and implementing the parts of the State health plan and plans of health systems agencies which relate to the government of the State. The agency prepares a preliminary State plan from the health systems plans for approval or disapproval by the Statewide Health Coordinating Council (SHCC), it also prepares and assists the Council in the review of the State medical facilities plan (SMFP) and in the performance of its functions. It serves as the designated planning agency under section 1122 (relating to capital expenditures review) of the Social Security Act, and reviews new institutional health services proposed in the State and the appropriateness of existing institutional health services.

SHPDAs are currently devoting 60 percent of their effort to performance of State agency functions as reflected by the following functional budget breakdowns submitted by 50 agencies:

Function	*Funds (percent)*
Administration of State administrative program	19
Performance of State agency functions	60
Administration of SMFP	16
Administration of HSA functions/section 1536	5
Total	100

Another study of the SHPDAs revealed the following information regarding the area of expertise of their professional staff:

Category	*Percent*
Administration	22
Health planning	29
Resource development	23
SHCC support	9
Other	17
Total	100

In terms of areas of expertise, the largest number of professional staff are assigned to the health planning category. Conversely, the smallest number are reported as being principally concerned with providing staff support to the Statewide Health Coordinating Council (SHCC). In the most recent study only 11 agencies indicated that they were providing staff support to the SHCC on a full-time basis.

SHPDAs have been establishing working relationships with those other agencies or programs that help make up large parts of the health care delivery system. About half of the State agencies have already analyzed the health needs of their States and established priorities. More than three-fourths of the agencies have provided guidance to HSAs on common format for health plans, procedures and a timetable for developing State health plans.

As of May 15, 1979, eight States have had their agencies fully designated in accordance with the terms of the Act. Most of the remaining State agencies have either submitted or will be submitting within the next year applications for full designation status. However, in one case—the State agency for Ohio, the Department of HEW has denied approval for full designation and given the agency a limited period of time in which to improve its performance. According to the Department, the Ohio agency has consistently overturned HSA efforts to restrict the building of additional hospital beds, often acting in direct conflict with its own State health facilities development plan.

In fiscal year 1977, statistics on SHPDA funding showed that the minimum Federal grant to 30 State agencies was $299,023. The average grant was $657,853, received by 22 agencies. Total Federal dollars for SHPDA funding reached $24.5 million in fiscal year 1977, with the total estimated Federal plus State dollars reaching a level of $39.1 million. In fiscal year 1978 for the 57 State agencies designated at that time, the minimum grant for 24 agencies was around $344,983, with the average grant for all agencies above the minimum amount set at $852,131 for a total Federal dollar contribution of $31.8 million. The combined Federal/State contribution for this activity in fiscal year 1978 was $48.9 million. It was estimated that the fiscal year 1979 amounts would be close to fiscal year 1978 levels, since appropriations for FY 1979 remain at the FY 1978 level.

STATEWIDE HEALTH COORDINATING COUNCILS

The law also mandated the creation of statewide health coordinating council as a joint forum for the interests and perspectives of the HSAs and State officials. All members of the council are appointed by the

Governor. At least 16 members must be chosen by the Governor from lists of representatives submitted by HSAs within the State. Each HSA is entitled to the same number of representatives on the SHCC. In addition to HSA representatives, the Governor may also appoint other persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC so long as these additional representatives constitute no more than 40 percent of the council membership. A majority of the SHCC members must be consumers of health care.

The council reviews annually and coordinates the health systems plans and annual implementation plans of the State's health systems agencies and makes comments on them to the Secretary of HEW. The SHCC is responsible for a State health plan (SHP) comprised of the health systems plans of HSAs within the State. It also reviews budgets and applications of health systems agencies, advises the State agency on the performance of its functions, and reviews and approves or disapproves State plans and applications for formula grants to the State under a number of Federal health programs.

As of February 9, 1979, 51 States have established their statewide health cordinating councils. These councils range in size from 13 members in Wyoming to 83 for Massachusetts. Total membership is 1,734. The membership of these councils reflects the membership of the HSA governing bodies with 53 percent classified as consumers. Of the providers, about 70 percent are direct providers.

CERTIFICATE-OF-NEED

Under Public Law 93–641 all States must develop a certificate-of-need (CON) program which assures that only those services, facilities, and organizations which are found to be needed by the planning agencies are offered or developed in the State. While some States have had certificate-of-need programs since the late 1960s, this is the first time that all States have been required to institute such programs. The certificate-of-need process attempts to prevent the duplication of services and facilities which exists in some locations—for example, hospitals within five minutes of each other offering identical high technology services with neither facility operating near capacity or even a minimum load for maintaining quality standards. Over the long run, CON attempts to create a more coordinated, regionalized system for health services.

Forty-one States have already enacted certificates of need laws, although their provisions vary widely. In addition, 33 States review capital expenditures under section 1122 of the Social Security Act. If a State disapproves a capital expenditure under the latter program, HEW will withhold depreciation and other costs related to that expenditure when reimbursing health care facilities under the medicare, medicaid, and maternal and child health programs. The following table shows the status of certificate of need and section 1122 programs in the States (as of January 1979) :

STATES WITH CERTIFICATES OF NEED AND SECTION 1122 PROGRAMS AS OF JANUARY 1979

State	Year certificate-of-need first enacted	Effective date of 1122 Review Agreement
Alabama	1977	September 1973.
Alaska (effective 1977)	1796	April 1974.
Arizona	1971	
Arkansas	[2] 1975	July 1973.
California	1969	
Colorado	[2] 1973	March 1974.
Connecticut	1969	
Delaware (effective 1979)	1978	July 1973.
(District of Columbia)	1960	
Florida	1972	
Georgia [1]	1974	February 1974.
Hawaii [2]	1974	
Idaho		February 1974.
Illinois	1974	
Indiana		July 1973.
Iowa (effective 1978)	1977	March 1973.
Kansas	[2] 1972	
Kentucky	1972	March 1974.
Louisiana		May 1973.
Maine	1978	March 1973.
Maryland	[2] 1968	
Massachusetts	1971	
Michigan	1972	December 1973.
Minnesota	1971	February 1974.
Mississippi		June 1973.
Missouri		
Montana	1975	February 1974.
Nebraska		February 1973.
Nevada	1971	March 1974.
New Hampshire		April 1973.
New Jersey	1971	February 1974.
New Mexico	1978	July 1973.
New York	1964	February 1974.
North Carolina	1978	April 1973.
North Dakota	[2] 1971	Feburary 1974.
Ohio	1975	
Oklahoma	1971	February 1974.
Oregon	1971	March 1974.
Pennsylvaina		March 1973.
Rhode Island	1968	
South Carolina	1971	March 1974.
South Dakota	1972	
Tennesse	1973	
Texas	1975	
Utah		February 1974.
Vermont		January 1975.
Virginia	[2] 1973	
Washington	1971	February 1974.
West Virginia	1977	March 1977.
Wisconsin	1977	
Wyoming	[2] 1977	February 1974.
Total number of programs	41	33.

[1] Covers nursing homes only.
[2] "Satisfactory" programs.

Source: Status of Certificate-of-Need and Section 1122 Programs in the States, Washington, D.C.; DHEW, Bureau of Health Planning; January 1979.

The certificate-of-need programs vary with each State, consistent with Federal requirements, although all must include requirements for approval of any new construction or significant capital expenditure. The certificate-of-need provisions of Public Law 93–641 were designed to improve upon the capital expenditure review provision (section 1122) of Public Law 92–603, the Social Security Amendments of 1972, which encouraged States to participate in capital expenditures review programs. In enacting the section 1122 program, Congress wanted to make certain that reimbursement for depreciation on buildings and equipment, and interest on loans used to acquire them, (items which are considered reimbursable as part of the cost of providing services under

the Medicare, medicaid, and maternal and Child Health programs), would be made in line with the then-designated planning agency's approvals.

The Department issued regulations specifying the minimum requirements for satisfactory State certificate-of-need programs on January 21, 1977. (These regulations were strengthened by revisions published in the Federal Register on April 8, 1977). These Federal certificate-of-need regulations, in setting forth the minimum requirements for State certificate-of-need programs, drew upon the experience of the State and the Department in administering previous certificate-of-need and section 1122 programs, so that the weaknesses of these earlier programs would be overcome. It should be noted that States can go well beyond the minimums established.

The Department now requires that State health planning and development agencies administer satisfactory certificate-of-need programs in order to become fully designated and thus to participate fully in the programs authorized by titles XV and XVI of the Public Health Service Act.[2] The HEW regional offices have the primary responsibility for providing assistance to the States in the development of satisfactory certificate-of-need programs.

The law mandates States to establish State certificate-of-need programs, satisfactory to the Secretary of HEW, which would apply to new institutional health services proposed to be offered or developed within the State. The CON program is to be administered by the State agency and is to contain sanctions (e.g., denial or revocation of licensure, civil or criminal penalties) so that only those services, facilities, and organizations found to be needed will actually be offered or developed in the State. Regulations spell out the types of new institutional health services which are subject to certificate-of-need review and the definition of a "health care facility" through, by, or on behalf of which such services would be made available.

The regulations require certificate-of-need approval for the following: (1) construction, development, or other establishment of a new health facility[3] or health maintenance organization; (2) capital expenditures over $150,000 except for site acquisitions, acquisition of existing facilities, or expenditures solely for termination or reduction in beds or services; (3) changes in bed capacity involving more than 10 beds or 10 percent of total capacity; (4) new services (except home health services) not offered regularly during the preceding 12-month period; and (5) predevelopment activity costing more than $150,000.

To address the issue of efficiency, applicants for certificates-of-need must make a written finding as to the efficiency and appropriateness of the use of similar existing facilities. In addition, local and State plan-

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[2] It is important to note that what is required of SHPDAs is that they *administer* a satisfactory certificate-of-need program, not that they enact a statute or develop a regulation. The SHPDA must secure whatever combination of authorities (statutory, regulatory, Attorney General opinions, and so forth) that may be necessary to administer a program meeting minimum Federal requirements. Further, State certificate-of-need programs may be more stringent or more comprehensive than the minimum Federal certificate-of-need standards.

[3] A "health care facility" is defined as including hospitals, psychiatric hospitals, skilled nursing facilities, kidney disease treatment centers, free-standing hemodialysis units, intermediate care facilities, and ambulatory surgical facilities, but not Christian Science sanatoriums. This definition of "health care facility" is the same as that used in revised regulations (Federal Register, January 21, 1977, pg. 4024) pertaining to section 1122 of the Social Security Act. "Limitation on Federal Participation for Capital Expenditure.

ning agencies must document in writing the cost, efficiency, and appropriateness of the proposed services, rather than relying solely on the word of the applicant.

Not included in certificate-of-need requirements are home health agencies (when not part of a health care facility), outpatient phsysical therapy, organized ambulatory care facilities, and physicians' offices. There remains some question whether medical equipment purchased by an independent practitioner, such as a pathologist or radiologist, and installed in facilities leased to the practitioner by a hospital are subject to certificate-of-need review.

The certificate-of-need review function required of State health planning and development agencies is intended to promote the more efficient allocation of scarce health resources. In every State and Territory, these agencies are gearing up for certificate-of-need review responsibilities. If this review responsibility is assumed in gradual fashion, with the proper foundation being laid in the way of review criteria, health plans, and Federal financial support, the committee feels this review should yield significant results. If this review program is structured to keep abreast of changes in the health care system (for example, the presence of institutional health services in noninstitutional settings) and if it is properly integrated with other regulatory mechanisms, such as rate review, the result should be a more efficient allocation of health resources in the country.

CENTERS FOR HEALTH PLANNING

Ten regional centers for health planning (authorizes under section 1534 of the act) have been funded under contracts to serve as back-up agencies for the local and State planning programs. These centers have produced a variety of products ranging from a guide to regulatory activities under P.L. 93–641 to an educational manual for HSA volunteers to an evaluation of the implications of capital limitation programs in the health industry. Staff size has ranged from three professionals and one support staff in region X to nine professionals and three support staff in region VI. The Bureau of Health Planning announced in February 1979 that it will reduce to four the number of centers to be funded under contract beginning in June 1979. This action represents part of a restructuring of the technical assistance program to improve use of funds and personnel.

GRANTS FOR STATE REVIEW

Section 1526 of the act authorized a program of demonstration grants to be awarded to State agencies for purposes of institutional rate regulation. Administration of this program was delegated to the Health Care Financing Administration (HCFA) which also has responsibility for administering the research and experimentation grant program for ratesetting authorized under section 222 of the Social Security Amendments of 1972—Public Law 92–603. Funds have not yet been awarded under the section 1526 authority. One obstacle to implementation of this section has been the act's requirement that the rate review demonstration program be conducted by the same agency—the SHPDA—having responsibility for health planning functions. At

present, State rate review or ratesetting activities are often conducted by separate commissions or other authorities independent of the SHPDA. According to Department spokesmen, the HEW Office of General Counsel has considered proposals to allow rate review grants to be made if the SHPDA and the ratesetting authority in the State are structurally organized under the same umbrella authority. With this consideration in mind, seven to nine State programs have tentatively been identified as possible future section 1526 bases. The act authorizes grants for such purposes to a maximum of six State programs.

NATIONAL HEALTH PLANNING INFORMATION CENTER

The National Health Planning Information Center was specifically authorized by section 1533 of the act to provide assistance to health systems agencies and State health planning and development agencies through a formalized system of information collection, processing, and dissemination.

It has been reported that, since the Center began operation on May 10, 1975, it has identified more than 12,000 documents relevant to health planning methods and technology and has abstracted, indexed, and stored on computer more than 5,000 of these items. More than 1,000 individuals and agencies directly involved in health planning have used its services, and many have taken advantage of the walk-in reference services.

HEALTH RESOURCES DEVELOPMENT

The second major part of the act, Title XVI—Health Resources Development—replaces the older medical facilities construction program best known as Hill-Burton. The new program authorizes funds predominately for modernization of medical facilities, construction of new outpatient or ambulatory facilities, and conversion of existing medical facilities for the provision of new health services. Money for construction of new inpatient medical facilities is available only in areas which have experienced rapid recent population growth.

The implementation of title XVI is also tied systematically to the entire health planning program, which was not true in previous facilities-oriented legislation. This not only has the advantage of enhancing the rational development of resources, but gives the planning side of the progam some further financial and political significance. For example, the State agency must have a State medical facilities plan (SMFP) which is approved by the SHCC, and is consistent with the State health plan. While it is a separate document, the SMFP is considered to be a more specific facilities-oriented part of the State's plan for improved health.

These features have meant that, until the planning structure is in place, most of title XVI cannot be implemented. The major exception is a project grant program authorized by section 1625 which provides some funds for construction or modernization of public medical facilities to eliminate or prevent imminent safety hazards or to avoid noncompliance with State or voluntary licensure or accreditation standards. Such projects grants are to be made only to a State or political

subdivision (including any city, town, county, borough, hospital district authority, or public or quasi-public corporation) for a project for a medical facility owned or operated by it.

Final regulations pertaining to this section of the law were published December 9, 1977. As of a January 25, 1977, deadline for applications for assistance under this program, 136 applications had been received requesting approximately $137.2 million in grant funds. Individual application grant requests ranged from a low of $8,000 to a high of $7 million. As of January 8, 1979, a total of $11.4 million in grant funds had been obligated to four projects. In FY 1978 congressional approval was obtained to reprogram approximately $40 million in formula grants under section 1602 authority for use under the section 1625 program. Subsequent to this action, $1.2 million has been obligated to one grant project under section 1625 and $38.7 million remains available through FY 1979.

Title XVI also authorizes an appropriation for HSAs to administer grants for planning and development activities identified in the health systems plan. These area health services development funds can be used to stimulate the development of needed services but cannot be used for actual delivery of services. Implementation of this part of the program is also contingent upon a fully operative health planning network. As a result, no funds have yet been appropriated for this activity.

FUNDING LEVELS

The following tables provide an appropriations history of health planning and predecessor programs and authorizations and appropriations under Public Law 93–641:

APPROPRIATIONS HISTORY OF HEALTH PLANNING AND RESOURCES DEVELOPMENT AND PREDECESSOR PROGRAMS

[In thousands of dollars; fiscal years]

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980 [1]
CHP	20,650	22,803	25,935	34,800	38,327	29,400	28,000				
Hill-Burton	185,123	196,521	308,204	203,578	210,445		[2] 51,760				
RMP	100,000	116,990	102,854	134,625	81,983	50,000	10,000				
Health planning	NA	NA	NA	NA	NA	10,000	90,000	[3] 130,000	145,000	143,000	145,400
Health facilities	NA	NA	NA	NA	NA		[4]		[4]		30,000
Total	306,773	336,314	436,993	373,003	330,834	89,400	180,350	130,000	145,000	143,000	175,400

[1] Administration proposal.
[2] This amount was used for sec. 1625 project grants, except for 1 percent of $517,600 set aside for program evaluation.
[3] $2,000,000 transferred to HCFA for rate regulation program.
[4] 22 percent (or $11,400,000) of the amount shown under the Hill-Burton program was used for sec. 1625 project grants in fiscal year 1976 and the balance (approximately $39,900,000) was reprogramed in fiscal year 1978 to provide additional funds for projects approved under sec. 1625 of title XVI. In addition, the used evaluation funds (as noted under footnote "2") were also made available for this purpose.

Source: Bureau of Health Planning, Office of Policy Development, Feb. 8, 1979.

AUTHORIZATIONS/APPROPRIATIONS UNDER PUBLIC LAW 93-641

[In thousands of dollars]

	Authorizations					Appropriation					
	1975	1976	1977	1978	1979	1975	1976	1977	1978	1979	1980 [1]
Health systems agencies	60,000	90,000	125,000	125,000	125,000	----	64,090	97,000	107,000	107,000	115,400
State agencies	25,000	30,000	35,000	35,000	35,000	----	19,000	24,500	29,500	29,500	30,00
Rate regulation	4,000	5,000	6,000	6,000	6,000	----	----	2,000	2,000	([2])	----
Centers for health planning	5,000	8,000	10,000	10,000	10,000	10,000	7,500	6,500	6,500	6,500	----
Area health services development	25,000	75,000	120,000	120,000	120,000	----	----	----	----	----	----
Health facilities construction:											
Sec. 1602 formula grants	125,000	130,000	135,000	135,000	135,000	----	[3] 51,760	----	----	----	----
Sec. 1625 project grants	----	----	----	----	67,500	67,500	----	----	----	----	----
Closure and conversion	----	----	----	----	----	----	----	----	----	----	30,000
Total	244,000	338,000	431,000	498,500	498,500	10,000	142,350	130,000	145,000	143,000	175,400

[1] Administration proposal.
[2] Program budget transferred to HCFA.
[3] 22 percent may be used for sec. 1625 project grants.

Source: Bureau of Health Planning, Office of Policy Development, Feb. 8, 1979.

VII. Committee Proposal

REVISION AND REPORTING ON THE NATIONAL GUIDELINES FOR HEALTH PLANNING

The proposed legislation requires the Secretary, at least 45 days before the initial publication of additional National Guidelines for Health Planning or the revision of existing or future Guidelines, to consult with and solicit recommendations and comments from the HSAs, the State health planning and development agencies and Statewide Health Coordinating Councils, the National Council on Health Planning and Development, and associations and specialty societies representing medical and other health care providers. In carrying out this provision, it is the Committee's expectation that HEW will provide material, including options under consideration, relative to the establishment or revision of the Guidelines to these organizations at least 45 days before the Guidelines are formally published as a Notice of Proposed Rulemaking.

The bill requires the Secretary of HEW to review annually the goals and standards established as part of the National Guidelines for Health Planning. In conducting this review the Secretary will review the health systems plans, the annual implementation plans and the State health plans which have been developed under title XV of the Public Health Service Act (PHS Act). The committee included

this provision in the bill in order to establish closer linkages between the planning which takes place at the local and State level and that which takes place at the Federal level. A critical examination of these plans will assist the Secretary in establishing new Guidelines as well as in revising existing Guidelines.

The bill also requires the Secretary to collect data to determine whether health care systems are moving in the direction of the standards and goals set forth in the National Guidelines and to determine the personnel, facilities, and other resources needed to meet the Guidelines. HSA's, State health planning and development agencies and other entities are required to assemble and report those data which are necessary for the Secretary to carry out this function. The Secretary may not require the health planning agencies to report data which are regularly collected by any entity of HEW.

It is the committee's intent that the Secretary be able to compare existing health care delivery systems with the guidelines as well as be able to estimate the personnel, facilities, and other resources needed by such systems for them to meet the goals and standards of the guidelines. If a bed-to-population ratio of 4 beds per 1,000 population is established as a goal for the Nation, the Secretary should know which health service areas are meeting that goal as well as the magnitude of changes in resources which is required to attain that goal; e.g., the number of additional or fewer hospital beds. It is expected that this information will be useful for national health planning and policy setting purposes as well as in the allocation of financial resources to those areas which are in greatest need.

The data necessary to accomplish this would be collected by the Secretary from HSAs, SHPDAs, the Cooperative Health Statistics System, as well as other entities. The committee is concerned that the requirements to assemble and report this data not be overly burdensome on the local and State health planning agencies and where practicable sampling should be used. The Secretary should clearly establish the requirements to be placed on planning agencies for this purpose. For example, the type and definitions of data and the manner in which they are to be reported should be established by the Secretary by regulations. In addition, some components of the Cooperative Health Statistics System or other existing data collection mechanisms should be expanded to collect some of this data. The committee expects the Department to move expeditiously in implementing the provision.

The Secretary is required to make periodic reports to the public about the relationship between the goals and standards with respect to and the status of the supply, distribution, and organization of health resources as well as a summary of the changes in resources required to meet the standards and goals.

In reviewing this provision of the law, the committee reaffirms its belief that the National Guidelines for Health Planning are an important part of the health planning program. The Guidelines are intended to serve as benchmarks which the HSA's and State agencies are to use in carrying out their planning activities. They are not to be inflexibly applied. The bill contains amendments in section 115 which make it clear that an HSA can establish goals and standards which differ from the national guidelines if conditions in its area require such adjustments.

Because the guidelines are national in scope, the committee is concerned that they set appropriate goals and standards for areas which are medically undeserved as well as for areas which have an excess of services and facilities. The committee expects HEW to insure that the guidelines recognize the unique circumstances and needs of medically undeserved populations, especially those in isolated rural communities.

The committee also is concerned with the limited resources which the Department seems to have devoted to the development and revision of the National Guidelines for Health Planning. During hearings before the subcommittee on Health and the Environment, for example, the Department testified that only two professional staff members were assigned to this important task on a full time basis. Yet substantial resources are necessary in order to carry out the required functions of consulting with the various interest groups, analyzing the health plans developed at the State and areawide level, and reviewing the adequacy of existing guidelines on an annual basis. In the committee's view, a specific unit within HEW, adequately staffed and situated organizationally such that it can draw upon all the appropriate resources of the Department, should be designated and charged with the task of developing additional and revising existing national guidelines.

The committee is also generally concerned with the administration of this program by the Department. Of the 14 sets of regulations which the Department has determined are needed for effective implementation of Public Law 93–641, only 5 have been issued in final form. Personnel and other problems in the Bureau of Health Planning and the Department's personnel and other administrative systems have caused one Bureau Director to resign. Few of the employees working on the planning program have worked in health planning agencies. While the current administration has accelerated efforts to implement the law, a number of problems still remain. The Committee encourages the Department to move rapidly to publish the regulation necessary to implement the program. Plans should also be made to provide existing Bureau employees with the opportunity to be assigned for short periods to health planning agencies and to recruit health planners with field experience to work in the Bureau.

NATIONAL HEALTH PRIORITIES; NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

The bill establishes several new national health priorities. The first, "the identification and discontinuance of duplicative or unneeded services and facilities", underlines the committee's concern with excess health facility capacity. The development of facilities and services when they are not needed or which result in underutilization of existing services or facilities adds to health care costs. Studies indicate that the nation may have as many as 100,000 excess hospital beds. Health Planning agencies must address this issue.

The second priority underscores the committee's intent that the health planning system establish and seek to implement cost containment goals and objectives. This priority calls for "the adoption of policies that will contain rapidly rising costs of health care delivery,

insure more appropriate use of health care services, and promote greater efficiency in the health care delivery system." The committee recognizes that cost containment objectives must be balanced against access and quality objectives. However, the committee is concerned that some HSAs have not established cost containment as a priority and thus have not given it adequate consideration.

In addition the proposal would add two mental health goal statements to the national health planning goals. These statements reiterate the legislative intent of the Congress in the enactment of the community mental health centers program. The goal statements call for: (1) the elimination of inappropriate placement in institutions of persons with mental health problems and the improvement of quality of care in institutions when such care is appropriate, and (2) the assurance of access to community mental health centers and other mental health care providers, thus emphasizing the provision of outpatient services as a preferable alternative to inpatient mental health services.

The reported bill, in addition, expands priority number (9) to include "the development and use of cost-saving technology". The committee notes that cost containment is one of the most important priorities in health planning. This priority has caused increasing concern about new technology and particularly the increases in costs which result from its use. Yet some technology can be used to lower total health care costs if properly used in the diagnosis and treatment process or in the management of health care institutions. The committee thus feels that greater emphasis needs to be placed on the development and appropriate use of such technology in order to increase the efficiency and productivity of our health care delivery system.

It is the committee's intent that health planning agencies give support to this goal by giving priority to the approval of projects which will reduce total costs. In carrying out its review of cost-saving projects, it may be necessary for planning agencies to get reasonable assurances that necessary management, utilization, or medical practice changes will be accomplished to assure that new technology will actually reduce costs, and that the savings produced will be reflected in reduced total costs to patients.

The reported bill would also require that not less than one member of the National Council on Health Planning and Development be an administrator of a private hospital. Because a major focus of the health planning program is on the planning and review of hospital services, the committee feels that it is important to have at least one person on the National Council with hospital management experience and expertise.

The committee is pleased with the recent activities of the National Council on Health Planning and Development and is encouraged by the Council's recent discussions concerning the delivery of health care throughout the United States. Important issues being addressed by the Council include productivity in the health care industry; the effect on capital formation of limitations on the growth of new hospital beds (which has implications for tax and reimbursement policy as well as Federal grant and private philanthropic efforts); closure and conversion of excess hospital capacity (which involves issues of health manpower as well as the provision of health care services); and the antitrust implications of the health planning law.

The committee believes that the National Council on Health Planning and Development can and should provide a public forum which is independent of other governmental units but which coordinates with them. Such a forum can be of great value in airing and integrating complex health care issues in discussing problems of health care in the United States and in proposing solutions.

THE ROLE OF COMPETITION IN THE ALLOCATION OF HEALTH SERVICES AND THE APPLICATION OF THE ANTITRUST LAWS TO HEALTH PLANNING AGENCIES

The Congress enacted the National Health Planning and Resources Development Act (Public Law 93–641) to deal with a range of health care problems two of which continue to plague our health care system—access and cost. In that Act Congress stated that (1) "the achievement of equal access to quality health care at a reasonable cost is a priority of the Federal government," and (2) "increases in the cost of health care, particularly for hospital stays, have been uncontrollable and inflationary and there are presently inadequate incentives for use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care."

In addressing these two problems Congress established planning agencies. These agencies are (1) to develop and implement health systems plans, which describe goals for a healthful environment and health system (including all necessary health services) which are responsive to the unique needs of the areas, and State health plans; (2) to determine the appropriate supply of institutional health services by recommending and approving only those new services and facilities that are needed (certificate of need); (3) to review existing institutional health services and determine their appropriateness (appropriateness review); and (4) to review the proposed uses in the area of Federal funds to develop new health services.

In establishing this health planning system the Congress did not address the role of competition in the planning or allocation of health services or the application of the antitrust laws to these planning agency activities. This lack of Congressional direction, particularly respecting the application of the antitrust laws, has created some confusion and concern about the legality of planning agencies undertaking the functions required of them in Public Law 93–641.

The committee's bill would make several clarifying amendments and the committee seeks, through this report, to explain the appropriate relationship between title XV of the Public Health Service Act and the antitrust laws and the appropriate interaction between health planning and competition.

Role of competition

In section 103 of the bill the committee sets forth findings that the market forces of supply and demand for many health services have been distorted and that, as a result, the interplay of purchaser and provider decisions regarding those services has not resulted in an appropriate allocation of supply of those health services. The section identifies (1) extensive coverage of health services by health insurance plans and (2) the methods of paying for health services by those health insurance plans, as specific sources of market distortion for inpatient

health services and other institutional health services. The result has been duplication and excess supply of those services (and facilities) as well as excessive use of those services. Primarily because of these third party reimbursement arrangements, individuals often make decisions respecting their use of institutional health service with almost no regard to the price of the services, and providers make decisions respecting the supply of institutional health services substantially unaffected by the usual financial incentives and risks which exist in other personal service industries. The committee notes that there are other factors which contribute to this distortion of market forces for institutional health services. The urgent nature of the need for some institutional health services, the rapid development of new technologies for the delivery of institutional health care services, and the predominant role of physicians in making purchasing decisions on behalf of the patient, thereby reducing the patient's opportunity to consider less costly alternatives, are all important factors.

This section of the committee's bill would make clear that for inpatient health services and other institutional health services for which market forces of supply and demand do not or will not appropriately allocate supply because of the effect of health insurance coverage and the methods of paying for institutional health care services under that insurance (and the other factors mentioned above), health systems agencies and State health planning and development agencies should take the actions authorized by title XV to allocate the supply of those services. The section also makes clear that for health services for which the market forces of supply and demand have not been distorted and will appropriately allocate the supply of those services, health systems agencies and State health planning and development agencies should in the performance of their functions under title XV give priority to actions which would strengthen the effect of market forces on the supply of those health services.

The committee believes that consideration in health planning of the role of competition can be integrated into current activities by the health planning agencies. The distortion of market forces has occurred primarily in the market for inpatient health services and for most other institutional health services. All institutional health services are currently required by title XV to be included in State certificate of need laws; and the committee's bill does not alter those coverage requirements. Where State certificate of need laws extend coverage beyond that required by title XV to non-institutional health services, the committee expects that the health planning agencies in those States would evaluate the factors which distort the market forces of supply and demand for those covered services. If an agency found that individuals, in making decisions respecting their use of those health services, are sensitive to the price of the service, and that any provider which developed services or facilities of that type would be at financial risk for low levels of utilization and the costs associated with excess unused capacity, then the planning agency should make certificate of need decisions which would strengthen the effects of market forces on the supply of those services. The committee would expect, however, that those health planning agencies would make a positive finding that market forces will appropriately allocate supply.

This new section would establish a fifth purpose of health systems agencies and an additional criteria for use by health system agencies and State health planning and development agencies in conducting their reviews. This new purpose describes the new responsibility which the committee's bill places on planning agencies to consider the role of competition in carrying out its functions. For those institutional health services for which an effective market does not function, planning agencies would use the certificate of need process to restrain increases in the cost of health services (section 1513(a)(3)) and prevent unnecessary duplication of health resources (section 1513(a)(4)). For other health services among which there is competition based on price and for which an effective market operates, planning agencies would strengthen the effect of those market forces of supply and demand by awarding sufficient certificates of need so that those market forces could operate to allocate the appropriate supply in response to consumer preferences.

The committee's decision to not include home health services or clinical laboratory services in the title XV requirements for coverage by State certificate of need programs, and its decision to prohibit coverage by State certificate of need programs of health maintenance organizations (HMOs), was based partially, in the cases of home health and clinical labs, and entirely, in the case of HMOs, on the committee's belief that the supply of those services would not be excessive if they were not regulated and that market forces of supply and demand may appropriately allocate them.

It is the committee's view that the scope of the planning agency functions of planning and appropriateness review would not be substantially altered by these new requirements. The health systems plan and the State health plan would include all health services, but the goals of the plan and the statement in those plans of changes in resources which are needed in the area (per section 115) might differ depending upon the agency's assessment of the extent to which, for a particular service, competition will limit the development of unneeded capacity and protect the public from its costs. For instance, plans could avoid establishing numerical goals or resource requirements by identifying where certain types of services are needed, or appear excessive, or by establishing a range for the number of new services needed.

The agency's review for appropriateness would include all institutional health and home health services, as required by this bill, and other services the agency chooses to include. The recommendations and findings could differ, as with health plans, depending upon the agency's assessment of the extent to which competition will allocate the supply of the service under review.

As the committee has pointed out, the market forces affecting institutional health services are sufficiently diminished that planning agencies should play a role in allocating the supply of those services. If however, an innovative financing, reimbursement or service delivery arrangement affecting institutional health services, were designed so that the method of payment by patients (1) created incentives for patients to respond to prices charged and (2) placed the providers at financial risk for unnecessary or excessive services; the committee

would expect that planning agencies would, in awarding certificates of need, consider whether the effect of that new arrangement will be to properly allocate the supply of those services. The committee expects that these types of new arrangements would likely involve a population enrolled with a provider on a prepaid basis for the delivery of a comprehensive range of services, including institutional health services.

The committee notes that its bill is consistent with the thrust of the January 1979 report of the President's National Commission for the Review of Antitrust Laws and Procedures. That report calls for increased competition to allocate supply wherever it will do so effectively. The committee generally agrees with the goals of the President's Commission and believes it has complied with them; but the committee is also convinced that there are distortions in the market forces of supply and demand for institutional health services which do not occur in other personal service industries. For this reason the committee believes that the health planning process, and particularly the certificate of need process is a necessary and effective regulatory mechanism to control the supply of institutional health services.

Antitrust laws

The basic objective of the antitrust laws, broadly stated, is to eliminate practices that interfere with free competition. The laws are designed to promote a vigorous and competitive economy in which each business has a full opportunity to compete on the basis of price, quality, and service. As noted previously, questions have been raised as to the relationship between title XV and the antitrust laws.

The committee believes that the antitrust laws should be aggressively enforced to ensure a vigorous and competitive economy where there is reason to believe that business will in fact compete on the basis of price, quality, and service. However, as indicated by the reported bill and this report, the committee believes there is currently little, if any, competition based on price among institutional health services. For those services unfettered competition could further aggravate existing health system problems—duplicative and unnecessary services and facilities and rapidly rising costs.

While the application of the antitrust laws to promote competition is and should be the general rule, the committee believes that a practical and realistic analysis of the health care industry argues for exceptions to the rule. In 1974 in enacting Public Law 93–641, Congress found that "(i)n recognition of the magnitude of the problems (of access and cost) . . . and the urgency placed on their solution" a system of health planning with certain well defined regulatory authority had to be established. As described in the second paragraph of this section of this report, Congress *required* health planning agencies to carry out specific functions and established a financial penalty for States which failed to comply with the requirements. Those statutory requirements and penalty indicate that Congress did not expect the antitrust laws to be applied to agency actions, which might otherwise be in violation of the antitrust laws, if those agency actions were necessary to carry out the prescribed functions. On the other hand, however, agency acts which are not necessary to carry out such func-

tions or which are outside the scope of title XV are not authorized and therefore not immune from the application of the antitrust laws.

In carrying out these functions, agencies will receive the views of providers and consumers at public hearings, develop health plans, make appropriateness review findings, and make recommendations and issue certificates of need for new institutional health services, capital expenditures, and major medical equipment. It is the committee's view that when health systems agencies, Statewide Health Coordinating Councils, and State health planning and development agencies carry out these functions by acting within the scope of the authority of title XV, there should be no doubt that Congress intended for no other Federal or State law, including antitrust laws, to prohibit those agencies from so acting.

Section 103 of the reported bill helps clarify this position of the committee on this matter. Under section 103, Congress calls upon HSAs and SHPDAs, when dealing with inpatient health services and other institutional health services, to substitute their judgement regarding the proper supply of those services for market forces of supply and demand which would otherwise allocate that supply. When recommending and issuing certificates of need for institutional health services, HSAs and SHPDAs would be strictly limiting supply to those services which the agencies determines are needed. In developing health systems plans and State health plans to cover institutional health services (including those which specifically identify excess or needed resources at specific institutions) and in recommending and making appropriateness review findings regarding institutional health services (including findings which identify specific institutions), HSAs and SHPDAs (and SHCCs) would be indirectly affecting the market forces of supply and demand for those services by advising consumers and providers as to their determination of the proper supply. In developing plans covering health services, other than institutional health services, for which there are reasons to believe there is competition based on price, HSAs, SHCCs and SHPDAs would establish goals which would strengthen the effect of the competitive forces. In those States where other than institutional health services are covered by certificate of need, HSAs and SHPDAs would award certificates of need in accordance with section 103 by considering the role which market forces of supply and demand play in allocating supply for the services under review. Even though such States have gone beyond the requirements of title XV by covering more than institutional health services (and HMOs before these amendments deleted them), it is the committee's understanding that the antitrust laws are not applicable because those planning agencies are acting under the requirements of State law.

The committee notes that the only Federal court decision to date on the relationship of the antitrust laws to health planning agencies is a March 1979 decision by the United States District Court for the Eastern District of Michigan in the case of *Huron Valley Hospital, Inc. v. City of Pontiac, et al.* That case involved the disapproval of the certificate of need application of the plantiff (Huron Valley Hospital) and a subsequent award of a certificate of need to defendant, Pontiac General Hospital. The court found that the activities of the defendant HSA and State planning agency of recommending and awarding a certificate of need were within the scope of the authority

of Michigan law and title XV and therefore were not violative of Federal antitrust laws.

To further resolve this issue the committee would amend section 1512(b)(4) (see section 110 of the bill) to provide immunity for the health systems agency from liability for the payment of money damages under any Federal or State law when the member of the board or the employee of the HSA who acted on behalf of the agency acted within the scope of his duty, exercised due care, and acted without malice. The committee included this provision to insure that when HSAs act within the specific authority of title XV the agency would not be subject to money damages, including treble damages under the antitrust laws.

DESIGNATION OF HEALTH SERVICE AREAS

The reported bill would allow the Secretary to redesignate the boundaries of an existing health service area if he determines after a public hearing that (1) the area is no longer appropriate for effective health planning and development, (2) the new area would be appropriate for that purpose, and (3) the new area better meets at least one of the other requirements of the law. These include requirements that the area include at least one center for the provision of highly specialized services; be of a certain minimum population; and be appropriately coordinated with PSRO area boundaries, existing regional planning areas, and State planning and administrative areas. In addition, all area boundaries must also take into account economic or geographic barriers to the receipt of service in nonmetropolitan areas; and must include an entire standard metropolitan statistical area unless an exception is granted. The committee expects that a hearing would be held in the area to be affected by the redesignation proposal.

In reviewing this section of the current law, the committee found that the current test for area redesignation is difficult to meet. It allows the Secretary to redesignate areas only if the existing area no longer satisfies the area designation requirements. The committee's amendment would allow area redesignation where the existing area no longer is appropriate for effective health planning and a new area would better satisfy the requirements of the act.

The committee's intent regarding redesignation though, is unchanged, a health service area boundary should be altered only when absolutely necessary and only after the Secretary balances the costs of redesignation (in terms of disruption to the health planning process, nonproductive changes in governing body membership, or erosion of local support for health planning) against any potential benefits from such redesignation. The committee expects that redesignation will occur in rare circumstances where there is no doubt that positive benefits will accrue for health planning in the area.

The reported bill also adds the Commonwealth of Puerto Rico to the States and territories eligible under section 1536 which provides that no health service area or HSA need be established and permits the SHPDA to perform the functions of the HSA.

DESIGNATION OF HEALTH SYSTEMS AGENCIES

The reported bill would increase the role of Governors in the HSA designation process by providing that the Secretary give priority to any application which has been recommended for approval by a Governor. It is the committee's intent that while each Governor's recommendation should be given considerable weight, the Secretary must make the designation decision based on his overall assessment of the applicant's capability of fulfilling the requirements and performing the functions of a health systems agency.

The bill requires that the SHPDA be given the opportunity to comment upon the performance of an HSA. Recommendations should focus on the way in which an HSA carries out its functions and on its ability to work together with other HSA's and the State to provide for effective health planning. Unless HSA's work together with the State in developing health plans and in carrying out certificate of need and other review activities, a rational system of planning and development cannot be implemented.

The reported bill authorizes the Secretary to enter into an agreement with a fully designated HSA for a period of up to 36 months rather than annually. The committee believes an HSA's performance can be monitored through regular reporting requirements. For those fully designated HSA's which are still expanding or developing their programs, the committee expects the Secretary to use a designation period of one to two years so that HEW can effectively monitor performance; but, as these HSAs mature and reach an appropriate level of performance, the committee expects that their designation agreements will be for three years. The extension of the current 12-month designation period for up to three years is intended to provide the HSA with a sense of permanence and to enable it to focus its attention on its planning and development functions.

The committee's bill also sets forth a process for the Secretary to terminate an agreement with an HSA if it does not comply with the provisions of the agreement. This process requires the Secretary to consult with the Governor and the SHCC, give the HSA adequate notice of the intention to terminate the designation agreement, and provide the HSA with a reasonable opportunity for a hearing. The Secretary may not terminate an agreement with an HSA without consultation with the National Council on Health Planning and Development. These same procedures apply to the Secretary's failure to renew a designation agreement.

The reported bill allows the Secretary, in cases in which an HSA is not meeting the requirements of section 1512(b) relating to legal structure, staff and governing body, to renew its designation agreement with conditions to assure its compliance with those requirements.

PLANNING GRANTS

The reported bill allows the Secretary, in cases in which an HSA in fiscal year 1980 to $200,000, $215,000 in fiscal year 1981 and $220,000 in fiscal year 1982. Grants made in fiscal year 1979 may be increased

on a pro rata basis to the 1980 minimum if appropriations are made for that purpose. It also authorizes the Secretary to use up to 5 percent of the appropriation for HSA planning grants to increase the budgets of those HSA's which have extraordinary expenses which cannot be met from their existing grants. Such expenses might include travel by staff and board members in a health service area which covers many square miles or is rural, a bi-state HSA's participation in the activities of more than one State, the development and operation of subarea councils in health service areas which are rural, coordination among HSA's in a divided SMSA, and unusual or extraordinary legal expenses, including those incurred by an HSA in defending against a lawsuit brought against the agency or any of its governing body members or staff in connection with the performance of their official duties.

The bill would change the existing HSA funding formula to one which recognizes economies of scale. The bill provides for an HSA to receive $.70 per capita for its first million population, $.50 per capita for its second million population and $.30 per capita for any population over 2 million. In addition, each HSA would be required to submit its budget to the Secretary for a determination of its appropriateness. The Secretary is expected to evaluate carefully the amount provided by the formula and assure that it can be put to good use by the HSA. If the Secretary determines that the total amount provided by the formula is not needed by the agency, after consultation with the SHPDA the amount of the grant may be reduced. Any funds that accrue from such reductions would be redistributed to the remaining agencies by formula. The committee is concerned that the Secretary not use this budget reduction mechanism in an arbitrary or punitive manner. Any HSA whose budget is proposed to be reduced should have an opportunity to present its views to the Department prior to any action being taken.

The committee proposal would authorize the Secretary to match non-Federal contributions to HSA's regardless of the size of their planning grants. Existing law does not provide for matching of non-Federal funds acquired by agencies at the minimum funding level. In the committee's view, all agencies should have non-Federal funds matched on an equal basis.

The committee is concerned that health systems agenices face considerable uncertainty about the amount of money which will be available to them for grants made during fiscal year 1979. The Department of Health, Education and Welfare has told a number of agencies that instead of being able to plan on $.49 per capita, which was the average per capita amount received by HSA's during fiscal year 1978, they should plan on receiving only $.44 per capita. Part of this reduction is caused by HEW's uncertainty about the local dollars which HSA's are likely to collect during the current fiscal year which HEW will match on a one-to-one basis. The committee's proposal includes an amendment which is designed to eliminate this problem by requiring that the amount of non-Federal funds collected the previous fiscal year will be used as a basis for determining federal match and the current fiscal year. The committee believes it is important for HSA's to know at the beginning of their grant year the amount of money which will

be made available to them so that they can prepare a budget and more effectively carry out the management of their health planning program.

CARRYOVER OF GRANT FUNDS

The proposed legislation provides that if a HSA or SHPDA receiving a planning grant or an entity of the State receiving grants for rate regulation have unobligated funds at the end of a fiscal year, those funds may be used in the following year as long as the designation agreement or grant remains in effect. However, if the Secretary finds that the amount of any carryover of funds plus the amount of the formula grant for the suceeding year results in a budget which is excessive or provides funds to an agency which it cannot effectively use, the committee expects the Secretary to make an appropriate reduction in the suceeding year's grant.

MEMBERSHIP REQUIREMENTS

The reported bill makes a number of changes in the membership requirements for HSA governing bodies. The legislation allows for the overrepresentation of rural areas by providing that the HSA membership shall include a percentage of individuals who reside in nonmetropolitan areas which is at least equal to the percentage of the population of the health service area of residents of those areas. In doing so, the committee notes the importance of having broad geographic representation on HSA governing bodes.

The bill clarifies that public elected officials and other representatives of general purpose local government are to be represented on an HSA governing body. This provision will assure that units of local government, through their elected leadership, have the right to appoint representatives to the HSA governing body. Such members can be included as either consumers or providers depending upon the applicability of the definition of provider of health care to that individual.

The committee did not adopt a proposal to establish a fixed percentage requirement for local elected officials. Instead, each health systems agency should seek an appropriate level of involvement of public elected officials in the planning process by having public elected officials serve on the HSA governing body or appoint representatives to it, or both.

A number of changes have been made in the classification of consumers on an HSA governing body. A provision is added to clarify that labor organizations are to be included among the major purchasers of health care who are required to be represented on the HSA governing body. In addition a consumer majority may include persons who in the last twelve months had been classified as indirect providers of health care. This change has been made to allow bona fide consumers who are serving on the boards of health care delivery organizations to leave those boards and be immediately qualified as consumers for the purposes of the HSA governing body criteria. In addition, those who are members of the immediate family of a provider, with the exception of the provider spouse, or who are board members of voluntary health organizations which do not have as their primary purpose

the delivery of health care, the conduct of research, or the conduct of health professional training, are no longer included under the definition of provider.

An amendment was also approved that would require that all HSA appointed subcommtitees and advisory groups have consumer majorities. Other provisions of this bill seek to enhance the ability of consumer members to participate actively in an HSA's activities. Even though some committees will deal with highly technical issues in which consumers may not have the requisite expertise, the committee, nevertheless, feels that their participation will serve an important educational function. However, the committee does not intend this provision to be interpreted to prohibit HSA's from obtaining advice or assistance from non-HSA advisory groups or medical or scientific organizations or panels, such as the local Professional Standards Review Organization. The committee notes that committees and advisory groups can be made up of both governing body members and non-members and that it is the committee's intent that committees and advisory groups be used as a vehicle to encourage broad participation in the activities of the HSA.

The reported bill includes a provision which would change the provisions of existing law that requires that the consumer membership of the HSA governing body be broadly representative of the social, economic, linguistic, and racial populations with a requirement that consumer membership include individuals representing the principal social, economic, linguistic, handicapped, and racial populations of the area. Adoption of the amendment reflects the committee's concern about the way in which HEW has defined the term "broadly representative" to mean "roughly approximate" of a groups percentage in the population. Uncertainty over the definition has lead to several suits and confusion among health systems agencies as to whether or not they are in compliance with the law. The committee rejects the notion that appropriate representation requires a quota of members of each sub-group or that each sub-group from the population be represented in proportion to its percentage of the population. But at the same time the committee expects that the HSA will include more than token representation of each sub-group which composes a substantial percentage of the population. The amended language requires that the HSA identify the major social, economic, linguistic, handicapped, and racial sub-groups in its area and assure that the perspective of each is represented. The perspective of individuals representing the geographic areas of the health service area and major purchasers of health care (including labor organizations) must also be represented.

The committee has added the handicapped to the population groups that require representation. The committee feels that it is important that the perspective of the handicapped be represented on the HSA governing body so that their unique health needs and access problems can be adequately considered.

Likewise, the committee proposal makes a number of changes in the definition and requirements for provider representation. The bill requires provider members of the HSA to be residents of, or have their principal place of business in the health service area. It requires the dean of at least one school of medicine or his representative to participate on the governing body if there is such a school in the area. It

also makes provision for the participation of at least one person engaged in the administration of a hospital to serve on the HSA. Since hospitals are the major focus of health planning and review activities, the committee feels strongly that a hospital representative should participate in the planning process. The bill would add podiatrists, physician assistants and individuals representing rehabilitation facilities to the examples of providers who may serve on the HSA governing body. Under the proposed legislation, one half, rather than one third, of the provider representatives of the governing body must be direct providers of health care. In doing so, the committee underlined the importance of having a broad range of individuals who are directly involved in the provision of health care services, both physical and mental, actively involved in the planning process. In instances in which a Veterans' Administration representative is required to be on the HSA governing body, the HSA may increase the size of its governing body or executive committee by one. Finally, the committee proposal clarifies the definition of provider by deleting the notion of indirect provider. However, the category of direct provider as a subset of the provider definition would be retained. The bill would increase from one-tenth to one-third the amount of gross income from health sources which would classify an individual as a provider. The committee notes that the providers specified in amended section 1531(3)(A) are only illustrative of those who should be included in health planning as direct providers.

The proposed legislation would also require that each HSA board include (through consumer and provider members) individuals knowledgeable about mental health services (including substance abuse). Consistent with current practice, the committee has vested ultimate responsibility for the mental health goals of the HSP with the HSA board. For that reason, the committee proposal would require that individuals knowledgeable about mental health be included in the membership of each HSA board. Thought was given to mandating that a certain percentage of the membership of each board be comprised of mental health representatives, but was rejected in order to provide maximum flexibility for each HSA in determining its own composition. The committee intends that its legislative requirement be interpreted such that it could be met by the inclusion of two individuals (one provider and one consumer) knowledgeable about mental health services on each HSA board.

GOVERNING BODY SELECTION

The reported bill requires that the HSA establish a process for the selection of members of its governing body which to the extent permitted by State law applicable for the incorporation of the agency, is designed to assure that there is the opportunity for broad participation in the nomination and selection process by the residents of health service area and that participation be encouraged. Residents of the area, for example, might be informed of upcoming governing body vacancies so that interested community residents could have their names considered for the vacancies. The committee is concerned that those who desire to become involved in the health planning process have an opportunity to do so. The committee recognizes that in some

States any change in the way in which a governing body is selected may involve a change in their organization's charter. The committee wishes to make it clear that nothing in this amendment is meant to jeopardize the legal status of the agency or require the agency to undertake action which is not permitted by State law.

At the same time concern has been expressed that the existing law even with these amendments might permit a small group of individuals to gain and maintain control of an HSA. The purpose of this amendment is to avoid a self-perpetuating governing body by assuring that the nomination and selection process is an open one and that the existing governing body does not have total control over it. A number of mechanisms are open to the HSA to accomplish this end; however, the committee feels that each HSA should have the flexibility to carry out this provision in a way that is best for this area.

RESPONSIBILITIES OF GOVERNING BODIES

The reported bill seeks to better define the relationship in a public health system between public regional planning body or a unit of general purpose local government and its separate governing body for health planning. In these 22 existing HSA's the public board would have responsibility for the establishment of personnel rules and practices for the staff of the agency and for the agency's budget unless such functions are specifically delegated to the governing body for health planning. The bill also provides that the public board shall appoint the members of the governing body for health planning. In addition Section 115 of the bill provides that the public board shall have an opportunity to comment and suggest changes in the health plans developed by the governing body.

The committee feels that in a public HSA, the public body should have overall responsibility for the budget and personnel rules and have the ability to review the agency's basic policy documents, that is the health systems plan and agency implementation plan. The separate governing body for health planning would have authority to carry out all other functions.

The committee did not adopt a proposal that the public body become involved in individual project review decisions or serve as an appeal body on decisions made by the separate governing body for health planning. The committee recognizes the potential for conflict between economic development goals of a community and sound health planning within a public health systems agency. Health planning has been established so that there will be adequate but not excess health services and facilities within a community. For health planning the notion of more is not always better. The committee is concerned that a public HSA may have a tendency to place priority on economic development or other goals to the detriment of the establishment of an efficient and cost effective health care delivery system. The committee expects the Secretary to monitor public HSAs particularly in light of the bills proposed changes allowing the public board of a public HSA to exert more influence over the planning process and to assure that appropriate health planning goals and objectives are those used for health planning decisions.

The committee bill also requires that a health systems agency which chooses to have a governing body of more than 30 members establish an executive committee which has authority to take action for the governing body that is composed of not less than 10 nor more than 30 members.

Existing law would allow the size of a governing body of a health systems agency to exceed thirty members if the governing body has established an executive committee and has delegated to that committee the authority to take such action (other than the establishment and revision of health plans) as the governing body is authorized to take. It is the committee's view that this provision allows either the governing body or the executive committee to make decisions required of the health systems agency. The committee would expect the Secretary to monitor HSA activity with respect to this issue to assure that the division of responsibility between the governing body and the executive committee is one that leads to efficient operation of the agency and timely decisions.

Section 1512(b)(4) currently provides that no member or employee of an HSA shall, by reason of his performance of any duty required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any Federal or State law if he acted within the scope of the duty of the agency, exercised due care, and acted without malice toward any person affected by it. The committee's bill would clarify this immunity and extend it to the health systems agency.

Current law, regarding liability of individuals, is amended to clarify (1) that the "member . . . of a health systems agency" must be a member of the governing body of the HSA; (2) that the individual member or employee must be acting on behalf of the agency and carrying out an action authorized to be undertaken by the agency; and (3) that the individual member or employee must act within the scope of that person's duty as a member or employee.

A health systems agency may not be made liable for the payment of damages under any Federal or State law for the performance of a duty, function, or activity authorized to be undertaken by an HSA or required of an HSA. This immunity applies only to a duty, function, or activity performed on behalf of the agency by a governing body member or employee and then only if the member or employee acted within the scope of his duty, function, or activity, exercised due care, and acted without malice toward any person affected by his performance.

The committee's amendment clarifies the scope of the immunity from liability of members, employees, and the agency. The immunity provided extends only to the statutorily authorized functions of a health systems agency (such as developing plans, recommending certificates of need, etc.) and does not provide immunity from liability for damages for bodily injury to individuals or physical damage to property sought in a civil action against a health systems agency or any other member of the governing body of or employee of a health systems agency.

The committee's intent in extending immunity from liability for money damages from individuals to the agency is to protect the agency when it carries out activities which are authorized by title XV. If

agencies of their members or employees act outside the scope of their authority under title XV they would be liable for the payment of money damages under any applicable law.

MEETINGS AND RECORDS

The reported bill modifies existing law such that (1) the HSA will not be required to conduct in public those portions of business meetings dealing with personnel matters or participation in judicial proceedings; and (2) records and data on agency personnel or participation in judicial proceedings will not have to be made available to the public. Existing requirements on the SHPDA are modified so that it may act in accordance with State law in giving notice to the public about and in conducting meetings and in making its records and data available to the public. Existing law has very broad sunshine provisions requiring the HSA and SHPDA to conduct business meetings in public and to make its records and data available upon request, to the public. This provision has made it difficult for some agencies to develop and carry out policies with respect to personnel, including decisions relating to the hiring and firing of agency staff, and to discussing litigation in which the HSA is participating.

At the same time the reported bill extends the sunshine provision to all units of the HSA. It provides that an executive committee or other entity appointed by the governing body shall (1) conduct in public its business and meetings, except for those parts of meetings which involve matters respecting personnel of the agency or participation in judicial proceedings; and (2) give adequate notice of its meetings to those persons who have requested such notice.

The committee wishes to point out that the provisions for public notice of meetings of the HSA, the executive committee and other committees requires that adequate notice of its meetings be given only to those persons who requested such notice. The committee believes that sending a newsletter to such persons who have requested or shown an interest in the HSA's meetings should be adequate to carry out this provision of the bill.

The committee expects that each HSA will establish procedures to govern, in accordance with these amendments, the closing of agency or committee meetings and the withholding of records and data. Those procedures should provide that a majority of the members of the board or committee (whichever is applicable) must vote to withhold any record or data or to close a meeting of the board or committee; that the public notice of the agency or committee meeting include a statement as to whether any portion of the meeting will be closed; and that if a meeting is announced as being opened, and it is subsequently determined that part or all of the meeting should be closed, that it will be closed only after a majority vote.

SUPPORT AND REIMBURSEMENT FOR MEMBERS OF GOVERNING BODIES

The bill requires each HSA to establish a program for providing assistance to members of its governing body, executive committee and other committees to enhance their decisionmaking abilities. Such a program would include a mechanism to determine the needs

of the members as well as a plan and mechanism for meeting those needs including the provision of training and continuing education. In the development of its program, an HSA should recognize the differing needs which consumers and providers may have for support and training.

In addition, the bill requires that at least one member of the HSA staff be designated as having responsibility for assuring that the members, particularly consumer members, of the governing body are provided with the information and technical assistance necessary to effectively perform their functions. The committee feels that this is an important responsibility given that consumers generally have less familiarity with health care issues and medical practices than provider members of the board. In carrying out this function the staff assigned this responsibility might, for example, provide: members with special analyses of plans or project applications highlighting special issues of concern; special sessions for members before or after meetings to review issues of particular interest to consumers; special readings or special training sessions designed to meet articulated needs of new members of the HSA.

The reported bill also provides that an HSA can make advances to HSA members to cover costs incurred in attending governing body meetings. The committee recognizes the extensive time and effort which governing body members must expend in carrying out their responsibilities and feel that financial barriers or disincentives should be removed in order to maximize active participation of all members. If financial barriers are limiting participation in committees and on task forces, an HSA may want to extend this policy, perhaps on a selective basis, to meetings of these groups as well.

CONFLICTS OF INTERESTS

The reported bill requires that no member of an HSA governing body or any of its subunits may vote on project or institutional reviews with which the member has a substantial ownership, employment, fiduciary, contractual, creditor, or consultive relationship. Each member who has or has had such a relationship shall make a written disclosure of such relationship before any action is taken on the matter and shall make such relationship public during the meeting in which action is taken. Similar provisions are added for the Statewide Health Coordinating Council.

The committee feels that it is important that all those who have or have had a conflict of interest in a matter before the Agency should declare that conflict and make it public in all matters before the agency. The applicability of the prior relationship conditions should be limited to a reasonable period of time by the Secretary in regulation. In addition, in carrying out the review functions (certificate of need, review and approval of proposed uses of Federal funds, and appropriateness review), a member with a conflict of interest would be prohibited from voting. The committee also recognizes that some agencies will desire to carry this policy further by requiring that those who have a competitive relationship with an institution whose proposal is under review disclose such relationship and by prohibiting such individuals from voting on the proposal.

STAFF EXPERTISE

The proposed legislation recognizes two additional types of staff expertise which each HSA should attempt to procure. These include expertise in financial and economic analysis and knowledge of the prevention of disease and other public health matters. The committee, however, recognizes that in some of the minimally funded or small agencies it may not be possible to acquire or include staff members with such knowledge and skill. In such cases, the HSA should provide an explanation to the Secretary with respect to its inability to carry out this provision.

HEALTH PLAN REQUIREMENTS

The reported bill requires that a SHPDA determine, after consultation with the Statewide Health Coordinating Council and other agencies of State government, such as the State Mental Health Authority, the State Maternal and Child Health Agency or the State Medicaid Agency, the needs of the State which are statewide. It further requires that each HSA in the development of its health system plan develop goals which are responsive to these statewide health needs.

The committee believes that, just as there is the requirement under current law for the Secretary to establish National Health Planning Guidelines, each State should articulate State health policy which reflects its statewide health needs. In the plan development process each HSA should take such policy into account as it does the National Health Planning Guidelines. It is the committee's expectation that the articulation of statewide health needs would build upon the National Guidelines; however, they should also address problems and policy issues that are unique to the specific State. It is the committee's hope that this articulation of statewide health needs will reflect a Governor's health policy and that, in the development of that policy, the SHPDA will adequately involve other agencies of State government which are responsible for the development and delivery of health services.

The bill also provides that the Governor of the State can disapprove the State health plan. However, the Governor's disapproval of the plan would be limited to cases where the plan does not effectively meet the established statewide health needs. If the plan is disapproved, the Governor is required to make public a detailed statement of the basis for his determination that the plan does not meet statewide needs and to specifiy the changes in the plan which are needed.

The committee seeks to encourage the Governor of each State to become more actively involved in the health planning process. This has been done through amendments just described which allow the State to establish State health policy at the beginning of the planning cycle in the form of statewide health needs and then to allow the Governor to approve the plan or disapprove it if it does not meet those needs.

The committee, however, wants to assure that the planning process remains one emphasizing local planning and decisionmaking and does not become over politicized at the State level. Therefore, the State health plan which is made up of HSPs can be established in one of three different ways: the plan can be approved by the Governor

following SHCC approval; the plan can become the State health plan following SHCC approval and no action by the Governor within 60 days; or the Governor may disapprove the State health plan if he finds that it does not meet predetermined statewide health needs and return it to the SHCC for reconsideration and approval, specifying the changes in the plan which he determines are needed. In the latter case, the committee would expect a process of negotiation to take place with the SHCC seriously considering the Governor's recommendation and attempting to revise the health plan while insuring that the integrity of the health systems plans is maintained.

The reported bill contains a number of amendments which seek to formalize the integration of mental health planning into the health planning process. While planning for mental health needs has always been considered by the committee to be an integral component of the health planning process, not all States have moved actively to improve mental health in their State health planning activities. The proposed legislation amends Title XV of the Public Health Service Act, section 237 of the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, and the Drug Abuse Office Treatment Act of 1972, and other related Acts to better integrate mental health planning into the national health planning process.

Under this proposal each health system agency would be required to include goals for the delivery of mental health services in their health systems plan (HSP). In developing such goals, each HSA would be required to appoint an advisory group or subcommittee composed of individuals knowledgeable about such services (including substance abuse) to be consulted with and to make recommendations with regard to such goals. The committee is aware that many, if not most, States have statutorily established Statewide networks for local mental health planning. In such States, the committee intends that each HSA first consider appointing the membership of that statutorily established body to serve as its advisory group. Such appointments, however, would have to be consistent with the titleXV requirements governing subcommittees and advisory groups of the HSA, and consideration would have to be given to the relationship of the HSA boundaries and the geographic boundaries established by the State for mental health planning purposes. If such arrangements are not practical, the committee would expect the HSA at a minimum to appoint significant membership from that body to the HSA's advisory group. In so doing, the committee expects to achieve, to the maximum extent possible—the coordination, and unification of purpose of mental health planning which may be mandated by the State, and that which is required under title XV.

A provision is also included in this legislative proposal which would allow an HSA to request, and to be authorized by order of the Secretary, to use one or more of its existing groups or subcommittees (in lieu of a new advisory group) to make recommendations regarding mental health goals. The committee has included this provision to accommodate those HSAs which have integrated or are integrating mental health planning into their overall planning process. The committee would expect the Secretary to issue an order of this sort only after a thorough review of each individual request and only after satisfying

himself that local mental health interests have been included to the extent contemplated by the described above. In making his determination on any individual request, the Secretary may wish to consult with, among others, the Governor of the State, the State health planning and development agency, the State Health Coordinating Council, and the director of the State Mental Health Authority, as well as the HSA board.

At the State level, the proposed legislation would require the SHPDA to provide an opportunity for the State Health Authority, the State Mental Health Authority, and other agencies of State government such as separate alcohol or drug abuse authorities designated by the Governor for such purposes, to (1) make written recommendations to the SHPDA concerning statewide health needs, and (2) review and make written recommendations on the goals and resource requirements of the HSPs before the SHPDA completes the preliminary State plan. Further provision is made that if the SHPDA does not take action on any such written recommendations, it must make public a written justification of its reasons for not accepting such recommendations.

The committee's intent in this area is to assure maximum involvement of all appropriate agencies of State government in the health planning process—both in the determination of the Statewide health needs and in the development of the preliminary State Health Plan. Because of the varying organizational structures of State government, the committee provides that the Governor of each State will designate those official agencies of State government, in addition to the State Health Authority and the State Mental Health Authority, which will participate in this process. The committee is clear in its intent that the SHPDA and the SHPDA alone remains ultimately responsible for the development of the preliminary State Health Plan. However, the committee does expect the SHPDA to receive and consider seriously all written recommendations from those agencies designated by the Governor for such purpose and, consistent with other requirements upon the SHPDA, to provide reasoned, written public justification for its rejection of any such recommendations. In this manner, the committee seeks to assure maximum public consideration of all relevant issues which may emerge during the plan development process.

The proposed legislation requires the State Mental Health Authority to designate a State Advisory Council to consult with it in carrying out its Federally mandated responsibilities. The Congress has already required this advisory committee under section 237 of the Community Mental Health Centers Act. The committee has further defined the membership requirements of this Council by requiring that a majority of members of the Council not be providers of health care and that the Council include representatives of entities concerned with both planning and service delivery. While making no such specific requirement, the committee notes that mental health authorities may wish to include on their advisory councils members of the HSA boards or advisory groups to the HSA boards who are charged with making recommendations about mental health goals.

Provision is also made to allow the State Health Coordinating Council (SHCC) to appoint an advisory group or subcommittee to assist it in reviewing the mental health goals and resource require-

ments (including substance abuse) of the State Health Plan. The committee through the intentional flexibility provided by its language has chosen to leave the decision to each SHCC as to whether or not such an additional group is necessary or desirable. The committee does note, however, that if a SHCC decides to appoint such a group, it may wish first to consider appointing the membership of the advisory council already established for such purpose by the Senate Mental Health Authority.

Finally, in attempting to further rationalize the planning process, the committee would require that plans developed under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972 be consistent with the title XV State Health Plan.

Throughout this portion of the proposed legislation addressing health planning requirements, the committee has repeatedly employed the parenthetical, "(including substance abuse)". In so doing, the committee reaffirms its interest in and concern for programs providing services in the area of substance abuse, and firmly establishes its intent: (1) that planning for such services must be an integral part of the national health planning process, and (2) that specific operating plans for such service programs must be consistent with title XV State Health Plans. For the purpose of this legislation, the committee intends the term "substance abuse" to mean alcoholism and alcohol abuse, and drug addiction, abuse, and dependency. It is the intent of the committee that individuals knowledgeable about such service programs and needs should serve on the advisory groups established by this legislation to the HSAs and, if the SHCC chooses to appoint such a group, to the SHCC. The committee has already made clear its intent that the HSA board membership provisions of this proposal could be satisfied by the inclusion of two individuals on the HSA Board. These two individuals should represent the broadest spectrum of mental health concerns, including substance abuse. Whether an HSA board chooses to include additional substance abuse representation among its membership, is a decision the committee leaves to each HSA; however, the committee wishes to make clear that it does understand that the number of individuals who can serve on an HSA Board is limited, and the committee does not wish to place any requirement on board composition beyond that already defined.

The proposed legislation removes the requirement that health system plans be consistent with the National Guidelines for Health Planning. It is the committee's expectation that each HSA will seriously consider and take into account the National Guidelines for Health Planning, but that if it has unique needs or resources in its area that require an adjustment in the Guidelines, the HSA will establish a goal or a standard that varies from the National Guidelines. In doing so, the HSA shall provide to the SHPDA and the SHCC a statement of the reasons for the inconsistency.

In proposing this change, the committee acknowledges the great concern that was expressed upon initial publication of the National Guidelines for Helath Planning in September of 1977. There was much misunderstanding about the purpose and impact of those National Guidelines. The Guidelines as initially published were not clear as to

the conditions which would allow an HSA to vary from them, nor were they clear as to whether or not they could be used to close health facilities. The revised Guidelines published in January 1978 went a long way toward clarifying these points and the Guidelines which were published as final regulations on March 28, 1978 make it clear that an HSA can adjust the Guidelines to meet special circumstances in its area. The committee's action emphasizes the fact that the Guidelines are intended to be benchmarks which the health planning system must consider in the development of its plans but are not rigid standards to which HSA must adhere. Each HSA should be able to demonstrate that it has considered and taken into account the National Guidelines in the development of its health systems plan as well as justify to the State agency any inconsistency with the guidelines. The Secretary in reviewing HSA performance should determine how well each HSA has considered the Guidelines in the development of its HSP and has justified any inconsistency with or need for adjustment from the Guidelines.

The reported bill requires that both the HSP and the AIP contain estimates of the resources that are required to carry out the goals and objectives which they contain. The HSP and the AIP shall include statements of the changes (through increases or reductions or both) in personnel, facilities, and other resources which the agency determines are required to meet the goals or objectives of the plans. In complying with this provision, it is the committee's expectation that each HSA will examine the cost and resources required for health systems implementation of each of the goals or objectives selected. It is hoped that this will insure that the HSA will develop realistic goals and propose reasonable actions to achieve them. Where a specific goal or objective calls for additional resources, the HSA should attempt to quantify them and assess the community's ability to provide them. Similarly, where a goal or objective involves the reduction of existing capacity, the HSA should identify the extent to which existing facilities or services should be closed, where facilities or services should be merged or better coordinated, and where existing facilities should be converted to other uses. The committee recognizes that the process of identifying excess capacity and developing of recommendations that specific institutions modify or cease to provide ongoing services will be controversial. However, the committee feels that such recommendations must be made if the system of health planning is to carry out its mandate successfully.

To emphasize its intent that plans become more specific the committee has included in the bill an amendment which makes it clear that a health systems agency may, as part of its statement of changes of resources required to meet the goals set forth in the plan, identify specific inpatient health care facilities which the agency determines should undertake such changes. Some health systems agencies have expressed concern that to undertake such actions may subject them to challenge under the antitrust laws. This amendment should alleviate those concerns by expressing the committee's intent with respect to such specific planning. When an agency intends to identify specific institutions as having services or facilities which are not needed to meet the goals of the plan, the committee expects that the agency will

establish hearing procedures to insure that each institution which provides the service or operates the facility under review will have an adequate opportunity to present all relevant information regarding their institution.

The reported bill deletes a provision of existing law which requires each HSA to develop and publish specific plans and projects for achieving the objectives established in the AIP. The committee believes that this level of detailed planning should which in many cases, is a function which can most appropriately be carried out by those organizations and institutions which have responsibility for the development and implementation of specific programs, not be required of all HSAs. The committee has required that both the HSPs and the AIPs become more detailed and include statements of the personnel, facilities, and other resources required to carry out the goals and objectives which they contain. Thus this added detail within the HSP and the AIP makes the requirement for additional specific plans unnecessary. The committee's action, however, is not meant to preclude an agency from developing such plans or carrying out such studies as are needed to achieve successful implementation of its plans.

The reported bill would require that if a health systems agency is a public regional planning body or a unit of general local government, the planning body or unit of government shall be given a reasonable opportunity to comment on the proposed health systems plan or annual implementation plan and to propose additions to and other revisions in it. Any such proposed additions or any other revisions not included in the HSP approved by the agency shall be appended to the HSP. It is the committee's view that a public HSA should have the ability to review the agency's basic policy documents and seek to modify it as appropriate but that final decision should be made by the separate governing body for health planning.

In establishing, reviewing, and amending its health systems plan, the committee expects each health systems agency to consider the special needs and circumstances of those health resources within its health service area which serve a patient community extending beyond its health service area jurisdiction. For example, the Mayo Clinic and the Cleveland Clinic Foundation and many other centers throughout the country draw patients from all parts of the country and the world. It is the committee's intent that the HSA in developing its plan provide recognition of the national role played by such resources in addition to the role such health resources play in a particular health service area.

A provision is added to clarify that the development and establishment of a health systems plan and annual implementation plan in a health service area which includes an area under the jurisdiction of an Indian tribe or an Alaska Native village does not affect the authority of that tribe or village to establish and carry out a health plan for the Indian health programs in the area under its jurisdiction. The committee notes that the Indian Self-Determination Act (Public Law 93–638), and the Indian Health Care Improvement Act (Public Law 94–434) authorize Indian tribes to plan for the health services on their reservations. Thus, if such a tribe or village does establish

a tribal-specific health plan, that plan shall be included in the health systems plan for the relevant health service area or areas. Indian tribes have expressed concern that confusion in this area has led to conflict between some tribes and HSAs and has inhibited full tribal participation in the health planning process. It is the committee's hope that this provision will establish the grounds for constructive working relationships between an HSA and any tribes or villages which are located in its health service area and result in improved health planning by both entities. While the bill (section 121) specifically requires the Secretary to issue regulations respecting the sharing of health planning data between the health systems agency and the Indian tribes and villages, it is hoped that the two entities will also seek other ways of coordinating their activities.

The committee bill also adds to current law the requirement that, in the establishment or revision of its AIP, or HSA conduct a public hearing on the plan and give interested persons an opportunity to submit their views. This requirement for public hearing and notification is identical to that required for the establishment of the HSP, and it is the committee's expectation that many HSAs would obtain public review of both the HSP and the AIP as part of a single process.

The proposed legislation would allow the health systems plan and the State health plan to be reviewed at least biennially and revised as necessary the plan adopted for its area. The committee feels this change is necessary in order to allow those agencies which have developed adequate plans to put increased emphasis on implementing them. The committee notes that some HSAs still have a considerable amount of work to make their plans into documents useful for decisionmaking. While the committee's proposal would allow this review to take place biennially the committee would expect, at least in their initial years, that health systems agencies review their plans on a more frequent basis. This will allow the HSA to fill out or add scope to the existing plans and to increase their specificity.

The Committee proposal also requires each SHCC to establish a uniform format for HSPs to facilitate the process of consolidating the HSPs into a State health plan. It is intended that the format include specifications related to plan organization and the method for presenting data. This requirement is not designed to preclude an HSA from experimenting with various methods of expressing its policy for improved health status and health services in its area. Rather, the intent is to facilitate plan development within a State by having the SHCC address minimum format and specify minimum statistics which must be included in each HSP. The Committee's expectation is that the HSAs and the State will work together to establish a realistic structure for the plan within the State.

CRITERIA AND PROCEDURES FOR REVIEW

The Committee proposal adds criteria which must be considered by planning agencies in the process of adopting standards for review of proposed health services. These include (1) consideration of the effect of the means proposed for the delivery of such new services on the clinical needs of health professions training programs in the area in which the services are to be provided; (2) if such services are to be

available in a limited number of facilities, the extent to which health professions schools in the area will have access to the services for training purposes; (3) the extent to which such proposed services will be accessible to all the residents of the area to be served by such services; (4) and the efficiency and appropriateness of use of existing services and facilities similar to those being proposed.

These four considerations address three specific concerns. The first is the need for the planning agency to consider in its project review activities the clinical needs of health manpower education. The Committee strongly believes that projects should not be approved based solely on training needs but should be based upon the needs of the area's consumers for a new health service. Given that an area needs a particular health service, the Committee believes that health planning and resource development objectives can be most cost effectively served by providing that a health service, when appropriate, may serve as a medical care, medical education, and medical research resource. All services need not support medical education, but enough services should be available for the training of health professionals so that duplicatives services are not required to be developed primarily for educational purposes.

Second, the planning agency should consider whether or not health services will be available to all of the residents of an area in need of such services. The Committee included this criterion because it received disturbing testimony that the services of numerous health care institutions are not accessible to some racial and lower income groups. The Committee notes that such alleged discrimination or selective admissions is in violation of title VI of the Civil Rights Act for institutions which have received Federal construction support under titles VI or XVI of the Public Health Service Act such policies or actions do not comply with assurances made by the institution that the facility will be available to all persons residing or employed in the areas served by the facility, and potentially do not comply with assurances made by the institution that a reasonable volume of services will be made available to persons who are unable to pay for them. This criterion expresses the Committee's belief that one of the primary purposes of the planning program is to increase and improve access to health care services. It requires the HSA to be cognizant of and thoroughly consider all circumstances, including those cited above, which pose barriers to access to health care services or facilities in the area. In implementing this criterion, though, the Committee does not intend or expect an HSA to carry out HEW's enforcement or compliance responsibilities under title VI of the Civil Rights Act or titles VI and XVI of the Public Health Service Act.

Third, the planning agency in approving a new service or facility should specifically consider the efficiency and appropriateness of the use of existing services and facilities similar to that proposed. This criterion is designed to assure that prior to adding a new facility or service the agency adequately consider the efficiency and cost effectiveness of existing services and facilities.

The proposed legislation also requires that each Statewide Health Coordinating Council use the criteria and procedure in Section 1532 in carrying out its own reviews. It further requires that the HSA, the State agency and the SHCC should cooperate in establishing review

procedures and criteria so that project review activities are coordinated within a State.

The reported bill requires the Secretary at least annually to review regulations promulgated under section 1532 and provide an opportunity for the submission of comments by health systems agencies, State agencies, and Statewide Health Coordinating Councils on the need for the revision of such regulations. At least 45 days before initial publication of a regulation proposing a revision of a regulation, the Secretary shall consult with and solicit the recommendations of these agencies. The committee, in adopting these amendments intends that the regulations set forth under section 1532 be reviewed on a regular basis to assure that they contain appropriate requirements for the health planning system. The amendment is structured in such a way to allow health planning agencies to provide the Secretary with the benefit of actual field experience as to how the requirements of the regulations work and what changes may be warranted. The committee notes that while an annual review is required, revisions are required only when the Secretary finds them to be necessary.

The committee proposal requires each HSA, State agency, and SHCC to develop procedures to assure that its requests for information in connection with a review are limited to only that information which is necessary to perform the review. It also modifies the provision of existing law providing for access by the general public to all applications reviewed and to all other material "pertinent" to the review by requiring that the material be essential to the review.

The reported bill also requires that each HSA, State agency and SHCC shall develop procedures to enable any person submitting data to designate data which he believes should not be released to the public and to submit such data separately. If an agency proposes to release for inspection any data so designated by the applicant the agency shall notify, in writing and by certified mail, the person who submitted the data of the intent to release the data. The agency shall then wait 30 days prior to the release of such data.

The committee wishes to make it clear that if a person submits data in connection with a review and designates it as data which should not be released to the public, the review shall not begin until the release of the data or determination that is not to be released and there shall not be included, in determining if the review was completed within the applicable period, the period of time beginning with the submission of the data and ending with its release or determination that it is not to be released.

CERTIFICATE OF NEED PROGRAMS

The reported bill amends title XV of the Public Health Service Act by adding section 1527 entitled "Certificate of Need Programs."

The new section requires that a State certificate of need program provide for the review and determination of need for major medical equipment, institutional health services, and capital expenditures. By so doing, the certificate of need coverage requirements are changed in three respects.

First the committee proposes to extend required certificate-of-need review to major medical equipment, defined as a single unit of equipment costing over $150,000, which is used to provide services to

inpatients regardless of ownership or physical location. The committee has taken this position because of its finding that such purchases are at times made by an individual other than hospital after the hospital's application has been denied by a health planning agency, even though the equipment will be used within or near the hospital to provide services to the hospital's inpatients.

The committee specifically rejected the proposition that review be required to be extended to major medical equipment used to provide services to individuals who are not inpatients of a hospital at the time the service is provided although States are not prohibited from extending their certificate of need programs beyond this minimum coverage. The reported bill does provide that any organization or person that plans to acquire major medical equipment shall notify the state agency of the intent thirty days prior to making the acquisition. The State agency will then be required to make a finding as to whether or not the proposed major medical equipment will in fact be used for inpatients. If the agency so finds, it can then require the submission of an application for a certificate of need.

The purchase of major medical equipment by independent clinical laboratories is not required to be reviewed. While the committee is concerned about the exclusion of any services from the planning and review process, it feels on balance that the inclusion of major medical equipment purchases by independent laboratories does not appear to be necessary at this time. The committee recommends that the Secretary monitor this situation and suggest any changes he finds are necessary.

Second, capital expenditures over the expenditures minimum are required to be covered under certificate of need programs. This provision is added to make certificate of need and Section 1122 of the Social Security Act more compatible.

The proposed legislation defines the term capital expenditure as an expenditure made by or on behalf of a health care facility which under generally accepted accounting principles is not properly chargeable as an expense of operation or maintenance or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part thereof, and which (1) exceeds the expenditure minimum, (2) substantially changes the bed capacity of the facility with respect to which the expenditure is made, or (3) substantially changes the services of the facility. Acquisitions of existing health facilities are not required to be reviewed unless there is a change in bed capacity or service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion or replacement of facilities which exceed the expenditure minimum also require certificate of need review. Cost in this case is intended to include staff expenses incurred by a facility or corporation in preparing a project as well as expenses incurred in obtaining consulting or other assistance. Donations of equipment or facilities to a health care facility require review if the equipment or facility would have been subject to review if it had been purchased or otherwise acquired.

The reported bill defines "expenditure minimum" to mean $150,000 for the twelve month period beginning with the month in which this

bill is enacted and, for each twelve month period thereafter, $150,000 or the figure in effect for the preceding twelve month period adjusted to reflect the change in the preceding twelve month period in the composite construction cost index maintained by the Department of Commerce. This provision of the bill would allow a State to index their capital expenditure threshold initially established at $150,000. However, the committee wishes to make it clear that a State can establish a constant threshold at $150,000 if it so desires.

Third, the bill would add rehabilitation facilities to the definition of those facilities which provide institutional health services and therefore subject them to certificate of need review. The term rehabilitation facilities is defined as an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision. While most if not all, inpatient rehabilitation facilities are currently included in the definition of health care facility, the committee wishes to highlight the need to include rehabilitation facilities in the health planning and review process.

The committee specifically considered and rejected a proposal to include home health services in the minimum requirements for a satisfactory certificate of need program. The committee feels that where competition can be encouraged in the health care industry, regulation of supply through certificate of need is unnecessary. Certificate of need regulation should be extended to only those services where the market forces of supply and demand will not appropriately allocate the supply of that service. The committee feels that home health services is a developing field and that competition between those who provide home health services should be encouraged. The committee will continue to examine whether market forces are at work to appropriately allocate supply and may return to this issue to evaluate more critically the structure of the home health services system.

The proposed bill requires that the certificate of need program ensure that only equipment, services, and capital expenditures found to be needed shall be acquired, offered, developed, or obligated.

The Committee received testimony that on occasion the review of a certificate of need application takes much longer than the 90-day period set forth for such review. Under existing law if a decision is not made within that period of time the applicant is in limbo. Such a practice could amount to a pocket-veto of the application. To resolve this situation, the Committee has adopted an amendment that would require the review of each certificate of need application be completed before the expiration of the 90-day period beginning on the date the State agency provides notice required by section 1532(b)(1). There are several exceptions to this requirement. First, when a State batches applications so that it considers two or more applications for a certificate of need, the period of review can be longer than 90 days if State law prescribes a longer period for such purposes. Second, when a request is made to the State agency for a hearing under section 1532(b)(8) on an application, the review of the application may take longer than 90 days if the State law prescribes a longer period for reviews involving such a hearing. The Committee feels that it is reasonable in cases where a hearing is requested to extend the period

beyond 90 days by another 60 to 90 days. Third, if an applicant and the State agency agree to a period of review of the applicant's application which is longer than 90 days or such longer period prescribed in State law, the review must be completed in the time period agreed upon. The Committee hopes that agreement can be reached between an applicant and State agency for a longer period of review in cases of large or complicated projects in which 90 days may not be adequate to carefully evaluate the proposal. If a review can not be completed within the above prescribed time, the application for the certificate shall be considered approved and the State shall issue the certificate.

In adopting this provision, the committee does not expect certificates of need to be issued due to the expiration of the specified time period and the lack of a timely finding of need by the State agency. The State agency has a responsibility to complete its review of the application within the prescribed time and to make a finding on the need for the equipment, services, or capital expenditure. Likewise, the committee does not expect State agencies to avoid tough decisions on certificates of need by allowing the time period to expire. If a pattern of such activity were to develop, the committee would expect the Secretary to review the State agency's performance and determine whether or not its designation should be terminated.

The committee's bill would also permit the State agency to delay the beginning of a review of, or to take longer than 90 days to review, a certificate of need application when the applicant institution has been cited by the Secretary of HEW for violations of Title VI of the Civil Rights Act of 1964. When the Secretary of HEW finds that a health institution is not in compliance with the requirements of Title VI and attempts and fails to get voluntary compliance by the institution with those requirements, the Secretary of HEW issues a "letter of findings of non-compliance." The committee's bill would permit the State agency to defer the beginning of a review or to suspend the review after the letter of findings of non-compliance is issued. The State agency's deferral or suspension may continue until (a) the Secretary has issued to the applicant a "letter of findings of compliance," or (b) a final decision of compliance is made either in the administrative process begun by the issuance by the Secretary of a "notice of deferral of Federal financial assistance" or after judicial review of such administrative process. The committee believes that a State agency should have discretion to defer the beginning of a review or to suspend a review until the State agency knows whether the health institution is in compliance with Title VI.

The reported bill requires approval of an application for a certificate of need for a capital expenditure which is required (1) to eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, (2) to comply with State licensure standards, or (3) to comply with accreditation standards compliance of which is required to receive reimbursement under Title XVIII of the Social Security Act or for payments under a State plan for medical assistance approved under Title XIX of such Act, but only to the extent that the capital expenditures required to eliminate or prevent such hazards or to comply with such standards. The committee, in adopting this proposal, is concerned that if an institution is required to make certain changes by one agency of

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government in order to remain in compliance with the law, it should not be prevented from doing so by the health planning system. It is the committee's intent that this provision apply to only those situations in which an institution or service would be required to close by a licensing or certifying entity if a capital expenditure were not made to eliminate or prevent such hazards or to comply with such standards. It is the institutions' obligation to provide the health planning agency with the necessary documentation that the institution or service will be required to close. The committee expects the health planning agency to make a judgment about each proposal and it is required to approve an application only to the extent that the capital expenditure is required to eliminate or prevent such hazards or to comply with such standards. It is the committee's intent that this provision apply only to those portions of a proposed project which the applicant is required to carry out by the certifying or licensing entity. Other portions of the project should be evaluated in relationship to the criteria which the agency has established. The committee would also expect that elimination of hazards or compliance with standards be carried out using the most cost effective means possible.

The committee expresses its concern with the practice of some State health planning and development agencies in conditioning a certificate of need approvals with conditions which do not seem to relate to application being reviewed. The committee recognizes that a SHPDA makes its determination of need for services based on many factors including the need of the population to be served, the availability of resources to provide services, proposed costs of the services, and access and quality issues. However, the committee would expect that conditions on approved certificate of need applications be related to the agency's adopted health plan or review criteria. Conditions such as that requiring a change in the composition board of trustees are not appropriate in the committee's view.

The bill provides that after a certificate of need is issued, review of the progress being made in making the equipment, facility, or service available for use shall be conducted annually. If it is determined that adequate progress is not being made, that is the timetable set forth in the application is not being met and the applicant is not making a good faith effort to meet it, the certificate shall be withdrawn. The Committee believes that the issuance of a certificate or need implies an obligation to the public to make such facility or service available at the earliest possible time. However, in certain cases, delays cannot be avoided, and the HSA and the State agency in their review of annual progress must consider whether the applicant has made a good faith attempt to carry out the project which was proposed and approved.

The bill requires that a certificate of need shall specify the maximum amount of a capital expenditure which may be obligated for an approved project. It also requires that the program prescribe the extent of additional review required of a project that exceeds the maximum capital expenditure approved. For example, a State might establish rules that no review would be required if there were less than a 5% overrun but require review if expenditures totaled more than that amount; alternatively, further review might be tied to increases in

excess of an inflation factor which would recognize construction cost increases.

The reported bill also requires that a certificate of need program provide an appeal mechanism to any applicant who is dissatisfied with a decision made under the program. The mechanism must be consistent with State law governing the practices and procedures of administrative agencies. The Committee believes, that if a State has such laws it should be allowed to use the procedures that would normally be used within the State, however, if the State has no such law, then the appeal should be heard by an entity, other than the SHPDA, designated by the Governor.

The bill requires that the certificate of need program provide that each decision of the State agency to issue a certificate of need shall not be inconsistent with the State health plan which is in effect. If the State health plan does not address the need for a type of service or facility or set forth criteria for its review, the HSA and the State agency would use other criteria which they have adopted pursuant to section 1532 to determine whether or not an expenditure, service or equipment should be approved.

The reported bill also requires that a certificate of need be issued by the State agency solely on the basis of the record established in administrative proceedings held with respect to the application for such certificate of need. It further requires that the Secretary of HEW shall not find a State certificate of need program to be satisfactory unless each determination of need is made solely on the basis of the review conducted in accordance with the procedures and criteria adopted by the program. This amendment expresses the expectation that the planning agency base its decision on the information developed pursuant to its review and contained in the review record and not on extraneous factors. It also addresses the committee's concern with respect to the practice in some States in which the State legislature enacts legislation directing the State agency to approve specific projects. Such legislative action circumvents the certificate of need process, and the committee would expect the Secretary to find a State's certificate of need program unsatisfactory if a pattern of such intervention were to develop.

The certificate of need program may conduct reviews in such a manner that comparisons of similar applications for certificates are made and priorities for approval are established. The provision allows for the batching of like or similar applications for certificate of need review. The committee feels that this approach will lead to more rational consideration of the need for new services since the first applicant to propose a new service or facility may not be best able to provide that service or facility in an effective or efficient fashion. If batching is to occur, it is expected that States would establish a period longer than 90 days to provide sufficient time for adequate consideration of proposals.

The proposed legislation would require each State to exempt certain providers from certificate of need requirements. Three categories of providers would not be required to obtain a certificate of need prior to the offering of an institutional health service, the acquisition of major medical equipment, or the obligation of a capital expenditure. These include (1) a health maintenance organization if

at least 75 percent of the patients who receive the institutional health service or the health service provided with such equipment or through such expenditure are enrolled with the HMO, (2) any other provider of health services which provides or otherwise makes available ambulatory and inpatient services on a prepaid basis to individuals enrolled with the provider to receive such ambulatory and inpatient services on such basis if at least 75 percent of the patients who receive the institutional health service or the health service provided with such equipment or through such expenditure are so enrolled, or (3) any other provider of health services if the provider has entered into agreements with one or more of the organization or providers of health services described in (1) or (2) if at least 75 percent of the annual revenues of the institutional health service or the health service provided with such equipment or through such expenditure will be provided by providers described in (1) or (2) under such agreements.

To receive an exemption, these providers would notify the HSA and the State agency 30 days in advance of any contractual agreements. The notice shall describe the service that will be offered and the basis for the provider's determination that the provider is exempt. No later than 15 months after the offering of a health service, the exempt organization or provider shall report to the HSA and the State agency, in the case of entities described in (1) or (2) above the percentage of patients receiving services who are enrolled on a prepaid basis, or in the case of a provider in (3) above the revenue received in the year reported under the agreements with prepaid providers.

If on the basis of the report the agency determines that the exempt organization or provider is not meeting the minimum requirement of 75 percent of the patients or 75 percent of the total revenues respetively the State agency shall notify in writing the organization or the provider that it shall not be permitted to use the service, equipment, or expenditure in the provision of health services to other than individuals enrolled with an organization or provider (described in (1) and (2) to receive health services on a prepaid basis. The committee expects the State to take whatever legal actions necessary to enforce the prohibition. The provider of health services which is not permitted to use the service or equipment provided except for individuals enrolled on a prepaid basis shall make annual reports to the State agency involved so that it can determine to provider's compliance with the requirement. The State agency shall notify the Secretary of HEW that the provider is prohibited from using such service, equipment, or expenditure to provide services to individuals who are entitled to Medicare benefits and for whom the provider would otherwise receive reimbursement under section 1815 of the Social Security Act for the provision of such services. The SHPDA shall also notify the State agency responsible for administering the State Medicaid programs. It is the committee's intent that the Secretary establish rules so that Medicare and Medicaid will not reimburse any of the costs of the service, equipment or expenditure other than the cost related to its beneficiaries receiving services on a prepaid basis. It is the committee's belief that it would be unreasonable for the Secretary to permit payment through Titles XVIII and XIX

of the Social Security Act for costs which may not be incurred for the benefit of Medicare and Medicaid beneficiaries.

If on the basis of reports filed. State agency determines that the provider is meeting the 75 percent requirement, the prohibition and penalty shall be removed.

The committee in adopting this amendment intends to encourage organizations, groups, and individual providers providing a range of ambulatory and inpatient services on a prepaid basis. The development of such groups should offer consumers a choice between prepaid care and fee for service care and the committee wishes to encourage the competition between those systems of care that will develop.

The reported bill includes a provision that would prohibit a State from covering the services, equipment and capital expenditures of a health maintenance organization for other than the minimum requirements set forth for certificate of need coverage in Title XV. The committee recognizes that this is a reversal of the provisions in current law which require certificate of need programs to cover health maintenance organizations. This has led to certificate of need coverage of the establishment of health maintenance organizations and of the ambulatory centers of health maintenance organizations. The committee is concerned that this requirement has placed health maintenance organizations on unequal footing with the fee for service sector since States are not required to cover the establishment or ambulatory facilities of fee for service providers. The committee thus feels that this prohibition is necessary to correct the problem created by the initial law.

Under existing law for purposes of health planning a health maintenance organization is defined in regulations prescribed under section 1122 of the Social Security Act. The Health Maintenance Organization Amendments of 1978, Public Law 95–559, removes the requirement that health maintenance organizations be covered under section 1122 and thus would delete the definition of health mainteance organization. However, it is the committee's intent that a similar definition to that contained in the regulations issued pursuant to section 1122 continue to be used for purposes of Title XV. For such purposes the heath maintenance organization should be defined to mean a public or private organization. organized under the laws of any State, which (1) provides or otherwise makes available to enrolled participants health care services. including at least the following basic health care services: usual physician services, hospitalization, laboratory, X-ray, emergency and preventive services, and out of area coverage; (2) is compensated (except for co-payment) for the provision of the basic health care services listed in (1) above to enrolled participants on a predetermined, periodic rate basis; and (3) provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) to arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

The reported bill contains a provision that requires that the need for the construction, expansion, modernization, acquisition of equipment, or addition of services shall be considered on the basis of the need for and availability in the community of services and facilities

for osteopathic and allopathic physicians and their patients. State agencies shall also consider an application in terms of its impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels. During the couse of the legislative hearings, the issue of discrimination against osteopathic facilities and services in the certificate of need process was raised by the osteopathic profession. A potential for such discrimination was recognized by the Secretary and promulgating regulations implementing the certificate of need provisions of Public Law 93–641. The testimony from the osteopathic profession seems to indicate that discrimination is taking place. While this amendment does not require separate consideration for osteopathic facilities it does seek to assure that the need for and availability of services and facilities for osteopathic physicians and patients will be considered.

The Secretary of HEW is required to modify existing regulations within 180 days of the date of enactment specifying the requirements of a certificate of need program which is satisfactory to the Secretary. The committee expects the Department to move rapidly on this matter so that States in turn can modify their existing certificate of need program to bring them into compliance with the law.

APPROPRIATENESS REVIEW

The reported bill modifies the requriement in existing law that HSAs and State Agencies review all institutional health services in their areas by providing that they review at least those instiutional health services which have been designated by the Secretary for appropriateness review. The bill also adds home health services to those services to be included in appropriateness review. In limiting the services which must be reviewed, the committee acknowledges the difficulty which health planning agencies would have in reviewing all institutional health services, given current resources provided for health planning. At the same time, it is particularly important to review those institutional health services which are least cost effective and most inappropriately used. In establishing minimum services for review, the committee expects the Secretary to consider the availability of the planning agencies' resources to carry out this function and to give priority to selecting those services which exhibit a pattern of high unit cost and those with low levels of occupancy or utilization. In this way, institutions will be encouraged to consider actions which consolidate or terminate services which are no longer needed.

The committee expects the HSA and SHPDA to examinine the appropriateness of existing institutional health and home health services in terms of their availability, accessibility, cost and quality. Other factors such as acceptability and continuity might also be addressed. The committee expects that, after giving consideration to the relevant criteria in section 1532(c), each agency will adopt criteria relating to these characteristics and apply them in its review of existing health services. The committee wishes to draw attention to the close relationship between the plan development and appropriateness review functions. Appropriateness review which entails a thorough examination of a specific service delivered throughout an

area will yield findings which will be helpful in developing or revising the health systems plan. The plan should include recommendations for dealing with problems identified in carrying out the review. At the same time, in carrying out the plan development function, services should be identified which require the detailed examination provided by appropriateness review.

The committee notes that appropriateness review findings can be made on either an areawide basis or institution-specific basis. The decision on how specific an appropriateness review recommendation or finding by the health systems agency or the State agency should be based upon the nature and the seriousness of the problem which makes the service inappropriate, its susceptibility to change, the amount of information the agency has about the problem, and judgments about how best to achieve needed changes within the agency's area. It is the committee's intent that agencies within each State make the decision on how best to handle this issue. It is the committee's expectation that over time agencies will be able to make detailed appropriateness review findings. Such findings should provide the consumer with better information about the health services which are available so that informed choices can be made about the institutions from which services are received. The committee notes the general lack of information on the part of the consumer about the services he receives and sees the appropriateness review function as one way in which the consumer can be provided with additional information about a service's availability, accessibility, cost and quality. For example, consumers should have information about underutilization of a service or unusually high mortality rates in an institution. Such specific findings should also provide institutions with recommendations of the changes which should take place to make the services of the area appropriate.

When an agency makes its recommendation on finding on an institution-specific basis, the committee expects that it will establish hearing procedures to ensure that each institution under review will have an adequate opportunity to present all relevant information regarding its services and facilities.

The committee did not adopt a provision which would require States to establish decertification programs which would assure that appropriateness review findings are implemented. Some see the appropriateness review findings are implemented. Some see the appropriatenesss review function as having limited value without clear sanctions which can be applied to assure actions are taken in response to appropriateness review findings. In the committee's view, however, a number of difficult problems with respect to decertification remain unresolved, including questions relating to the retirement of outstanding debt, employee rights, and physician privileges. While is is important that the existing health care system maintain only needed capacity, more study of these problems is needed before across-the-board action is taken.

The reported bill, therefore, establishes a demonstration grant program to States for reduction of excess capacity. The purpose of this program would be to demonstrate the effectiveness of various approaches for identifying and reducing excess capacity in the resources and facilities of hospitals. States would be given additional grant funds to engage in the following activities:

(1) Identifying excess hospital capacity (by geographic region or by health service);

(2) Developing programs to inform the public of the costs associated with excess hospital capacity;

(3) Developing programs to reduce excess hospital capacity in a manner which will produce the greatest savings in the cost of health care delivery;

(4) Developing mechanisms to overcome barriers to the reduction of excess hospital capacity; and

(5) Any other activity related to the reduction of excess hospital capacity.

Under the proposed legislation, $4 million is authorized to be appropriated for each of the next three fiscal years to implement this program.

This demonstration program is inteneded to help clarify and resolve some of the outstanding questions relating to the reduction of excess capacity. For example, it is clear that the closing of whole hospitals is more cost effective than closing units within a hospital or beds within a unit but the magnitude of the differences is not well known. Similarly, there is wide misunderstanding about the general costs of excess capacity and little public understanding of the need to increase the efficiency of the health care delivery system. Different approaches to educating the public in understanding these issues should be undertaken with the hope of raising public awareness of these problems to a point where action can be taken. In addition States may want to develop voluntary or mandatory programs to stimulate capacity reduction. A State program might involve developing closer linkages between the appropriateness review function of health planning and rate setting programs at the State level: developing a State fund from State general revenues or from a tax or levy on insurance premium dollars to reimburse hospitals for the retirement of outstanding debt and other costs related to closure; or developing licensure and related sanctions to bring about efficiencies in the delivery system.

The committee wishes to emphasize that neither this section or other sections of Title XV requires facilities that are found to be no longer needed to close. Such action can only be brought about by voluntary action or as a result of State law.

REVIEW AND APPROVAL OF PROPOSED USES OF FEDERAL FUNDS

The reported bill requires the SHCC to review any application submitted to the Secretary by a State or a grant or contract authorized under the Public Health Service Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and Section 409 of the Drug Abuse Office and Treatment Act of 1972 for projects which will affect more than one health service area. This amendment is made to avoid duplication of review activities of grants made to States which have a statewide impact or create a statewide program such as a communicable disease control program, a statewide emergency medical services network, or immunization initiatives. While the SHCC would have responsibility for reviewing such programs, it is expected that a copy of the application would be provided to each HSA so that

it would be aware of the proposed services and be in a position to advise the SHCC on the impact of such services on its health service area.

The reported bill provides for the SHCC to recommend approval or disapproval of any plan or application submitted to the Secretary as a condition of receipt of any funds under allotments made to a State under the Public Health Service Act and related Acts. If the SHCC recommends disapproval of a plan or application the Secretary, after making a finding that such plan or application is not in conformity with the State health plan, may not make Federal funds available under such State plan or application. However, if the Secretary makes such a finding, he shall notify the Governor of his finding and the reasons for it and advise him that he has 30 days in which to submit a revised plan or application that conforms with the State health plan. The existing law allows the SHCC to review and approve or disapprove any such application, and its decision is binding upon the Secretary unless the Governor of the State requests that the Secretary review the SHCC decision. The effect of the change, therefore, is to require the Secretary to act in the case of a SHCC disapproval of an application or plan without the specific request of a Governor of a State to reconsider the SHCC's recommendation.

Certain federally funded grants and contracts for research and training awarded under Titles IV, VII, and VIII of the Public Health Service Act do not require HSA review and approval under section 1513(e)(1)(B). The committee proposal deletes specific reference to these titles and refers instead to research and training grants and contracts. It is the committee's intent that all grants and contracts for research and training be subject to this same provision. The committee proposal also changes the basis for determining which grants and contracts are to be reviewed. Grants and contracts for research and training are to be reviewed if they are made, entered into, or used for the development, expansion or support of health resources which (a) in the case of grants or contracts for training, would make a significant change in the health services available in the health service area; or (b) in the case of grants and contracts for research, would significantly change the delivery of health services or the distribution or extent of health resources available to persons in the health service area other than those who are participants in the research. The committee notes that research often includes clinical trials. Such trials include demonstration projects designed to answer questions about the general applicability of procedures, drugs, or devices with potential usefulness that have not been tested in non-laboratory settings. The committee intends that such projects generally shall not be reviewed unless the project is to continue beyond the research stage and then only in cases where it would make a significant change on the services or resources in the area as described above.

The committee believes, however, that certain categories of research projects should be reviewed in all cases. They are: (1) projects invoving a demonstration of a therapeutic modality in which the terms of the funding commits public or private health care providers or health care institutions to the initiation, expansion, or continuation of demonstrated procedures; (2) demonstration projects where the equipment or personnel used in the demonstration will continue to be

used to provide health care services once the demonstration is over; and (3) demonstration where patients who are not part of the demonstration protocol can gain access to the procedures.

The committee would expect the Secretary to define the term "significant change" with respect to other research projects in a way which is similar if not identical to the thresholds established for a satisfactory certificate of need program. The definition of "significant change" in the health services available in a health service area as it relates to grants or contracts for training may need further definition. In that process the committee would expect the Secretary to consult with both those involved in health professions' education as well as those involved in health planning.

The reported bill provides that when a State is to make a grant or contract in a health service area from funds received under the covered acts, the Governor of the State shall allow each HSA 60 days to review the proposed uses of those funds in its area and approve or disapprove such use. The Governor, after taking into consideration on HSA's decision and any comments which the SHPDA has developed, may make such Federal funds available for use notwithstanding the disapproval of an HSA, only if the decision of the Governor is made available to the appropriate HSA and the SHPDA and contains a detailed statement of the reasons for the decision. Existing law requires the HSA to report recommendations on such uses of funds made by State government in its health service area to the Secretary. This change has been made because bringing the Secretary into the decision making process after a State has already received its grant funds is awkward and inappropriate.

COORDINATION OF HEALTH PLANNING WITH RATE REVIEW

The reported bill requires that the HSA and the SHPDA coordinate their activities with the activities of any entity of the State which reviews the budgets and rates of health care facilities. Such coordination might involve the sharing of data, reciprocal review of plans and other policy documents; joint development of criteria and standards for project review; provision by the rate review agency of advice on proposed capital expenditure projects; participation by the rate review agency in appropriateness review, particularly in determining the reasonableness of rates being established for a particular service; the use of reimbursement sanctions to enforce appropriateness review decisions; and the participation by the agency which reviews rates or budgets in educational or training sessions for health planning agency participants. To facilitate coordination, a health planning agency should consider entering into a written agreement with the rate review agency as well as the establishment of staff to be responsible for the interaction between the two organizations. The committee feels strongly that coordinating health planning activities with related review and regulatory programs is a high priority and that such coordination can maximize the effectiveness of both efforts.

The reported bill proposes a number of changes in Section 1526, grants for rate regulation. Specifically, it removes the restriction that a maximum of six States can participate and it allows the grant to be made to any unit of State government which desires to regulate

rates, and such that any State which shows an interest in demonstrating the effectiveness of regulating rates would be able to participate while removing the requirement that the SHPDA be the agency for rate review under this demonstration provision, it remains the primary purpose of these grants to demonstrate both the effectiveness of regulating rates and coordinating rate regulation activities with health planning at the State and areawide level. The committee would urge the Secretary to award grants to States which are willing to experiment with different organizational structures and which are innovative in their approaches to coordinating these two important functions.

COORDINATION WITHIN STANDARD METROPOLITAN STATISTICAL AREAS (SMSA'S) AND WITH OTHER ENTITIES

The reported bill requires that each HSA which has all or part of its health service area within a SMSA shall coordinate its activity with the activities of any other HSA which is serving the SMSA. Such coordination is to be carried out in accordance with a program developed by the HSAs and shall provide for the joint review of each HSP and AIP developed for each health service area, of the criteria used in making reviews affecting the area, and of each decision under certificate of need which affects the area. In addition, the committee hopes that a number of joint activities would evolve, including joint task forces on the establishment of planning goals for the SMSA, coordination and integrated use of data for the SMSA, and joint planning and review task forces.

The committee reiterates its intention that SMSAs not be divided except in rare instances. In cases where this has occurred and is necessary for effective health planning, the activities of the HSAs must be coordinated.

STATE HEALTH PLANNING DEVELOPMENT AGENCIES (SHPDA)

The reported bill requires the Secretary to provide each HSA within a State with an opportunity to comment on the performance of the State agency prior to the renewal of the designation agreement with the agency. The committee hopes that this provision will provide the Secretary with additional information about the performance of the SHPDA particularly with respect to its support of areawide health planning within the State in both the health plan development and project review and appropriateness review areas. The Secretary should seriously consider the comments of the HSA and, if necessary, add conditions to the designation agreement or grant to promote the development of a better coordinated health planning system within the State. The Secretary may not terminate or fail to renew an agreement before consulting the National Council on Health Planning and Development.

The bill allows the Secretary to enter into a designation agreement with a State for up to 36 months. It also sets forth a procedure for the Secretary to terminate or not renew an agreement with a SHPDA if it is not complying with the provisions of the agreement. This procedure requires the Secretary to consult with the SHCC, to give the SHPDA

adequate notice of its intention to terminate or not renew the designation agreement, and to provide the SHPDA with a reasonable opportunity for a hearing prior to a decision being made.

The legislation requires the SHPDA to prepare an inventory of the medical facilities, other than Federal facilities, located in the State and to evaluate on an ongoing basis the extent to which such facilities are in need of modernization or conversion to other uses. The results of this inventory and evaluation should be provided to the HSAs for use in their health plan development activities. The committee notes that this inventory function is not a new requirement but is currently required under Title XVI as part of the development of the State medical facilities plan. The reported bill repeals the provisions of title XVI which provides allotment grants for health care facility construction to States and requires the development of a State medical facilities plan. It is the committee's view that by including the inventory requirement, all the requirements necessary for sound health planning for health care services and facilities will be contained in Title XV; thus, the requirement for a separate State medical facilities plan is duplicative and no longer necessary. Decisions about the need for health care facility resources should take place after the HSA has identified the goals and related actions necessary to provide adequate health care services for its area. These goals and resource requirements should then be integrated into the State health plan by the SHPDA and approved by the SHCC. In doing so, both the HSA and the SHPDA may wish to summarize or consolidate the facility resource requirements in one section of the plan.

The reported bill clarifies and changes provisions of existing law which require that each State have a fully designated SHPDA by September 30, 1980 if the Secretary is to continue to make allotments, grants, loans, loan guarantees or contracts available under the Public Health Service Act, the Community Mental Health Centers Act, or the Comprehensive Alcoholic Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion or support of health resources in the State.

The first change would be to lessen the penalty from a withholding of all grants, loans, loan guarantees or contracts in the State to withholding grants and contracts entered into with the State. This would include both formula and project grants made to the State under the referenced Acts. The committee has adopted this change so that the penalty is placed on the State government which has the authority to comply with the law in order to avoid the penalty. The second change is to allow some States more time to comply with existing law and the new provisions added by these amendments. It would provide that the penalty would take effect if a State did not have a fully designated SHPDA upon the expiration of (1) September 30, 1980, (2) the first regular session of the legislature of the State which begins after the promulgation of regulations under section 117(e) of these amendments dealing with certificate of need requirements, or (3) the sixth month after the month in which such regulations are promulgated whichever occurs later. The committee has adopted this provision to allow each State to have adequate time to meet the requirement in law as modified by these amendments. The committee hopes that States will move

ahead aggressively to develop effective planning programs and come into compliance with the law well before the date the penalty would become effective.

The reported bill will allow the Secretary to extend the period of a conditional designation agreement for a State health planning and development agency for such additional time as he finds appropriate if he finds that the designated State agency is making a good faith effort to comply with the requirements of section 1523. The committee hopes that few States will need additional time but recognizes that delays in establishing the requirements for a satisfactory certificate of need program and other requirements of the programs have hampered some States in moving toward full designation. The committee intends that one of the important factors to be used by the Secretary in determining whether a State is making a good faith effort to comply with the requirements of section 1523 would be serious legislative activity to establish a satisfactory certificate of need program.

STATEWIDE HEALTH COORDINATION COUNCIL COMPOSITION

The reported bill provides that an interstate HSA shall have a number of representatives on the SHCC based on the relationship of the population of that portion of its health service area in the State to the population of the largest health service area within the State. However, each such interstate HSA shall have at least one representative on the SHCC.

The committee proposal also provides that in States which have more than 10 health systems agencies, each HSA is entitled to only one HSA representative on the SHCC rather than two representatives as would be the case in other States. This provision was adopted so that the size of the SHCC can be kept manageable in States that have a large number of HSA's. The committee wishes to point out that while HSAs in States with more than 10 HSAs would be entitled to only one representative, this would not preclude the Governor from allowing each HSA to have more than one representative and therefore establishing a larger Statewide health Coordinating Council.

The bill also provides that each Agency submit to the Governor two nominees for the SHCC for each representative to which the Agency is entitled. The Governor may select, by and with the advice and consent of the State senate, or, in the case of a State with a unicameral legislature, of the State legislature, the chairman of the SHCC from the members of the SHCC. Of the provider members of the SHCC, at least one-half must be direct providers as defined in section 1531(a) and at least one must be a person engaged in the administration of a hospital.

AUTHORIZATIONS

The reported bill provides authorizations of appropriations for each of fiscal years 1980, 1981 and 1982 for HSAs, SHPDAs, State rate setting demonstrations, technical assistance, and the area health service development fund. The committee wishes to note that as more

health systems agencies and State agencies become fully designated and assume other requirements and responsibilities called for under the Act, and as other legislation which have been or are being considered provides additional responsibilities for the health planning system, adequate Federal financing of the planning program will be essential to its success.

The committee is dismayed that no funds have been requested or appropriated for the area health services development fund. When the legislation was enacted in 1974, there were strong feelings that HSAs should have the ability to stimulate the development of additional health services where they were needed in addition to the authority under the certificate of need and other regulatory programs to prevent the development of services where they were unneeded. The area health services development fund was intended to provide the health planning agency with seed money to assist others with the planning and development of needed services within its health service area. Now that HSAs have become fully designated and have developed plans which clearly identify where such development funds could be properly used, the committee feels that it is important that funds be available for this purpose. The committee also expects the Department to move aggressively to develop the guidelines and regulations necessary to implement this portion of the law.

REPORT ON EFFECTIVENESS OF PLANNING LAW

The reported bill requires the Secretary to report to the Congress on the results of his review under section 1535 to determine the extent to which the health of the residents of the areas has been improved; the accessibility, acceptability, continuity and quality of health care has been improved; and the increases in costs of the provision of health care have been restrained. The committee recognizes that it will be difficult to show a causal relationship between these outcome indicators and health planning agency performance. Much of what health planning agencies do involves getting others, hospitals, other providers and consumers, to take the actions necessary to improve the health care delivery system and access to services. Thus, the health planning agency acts as a catalyst for change and not as a direct implementor of change. However, through that catalytic action, improvement in the health care system and in health status can be brought about; it is the committee's intent that the Secretary make a concerted effort to analyze and summarize these changes.

To accomplish this, it is critical that the Department institute a systematic program of periodically assessing the performance of both health systems agencies and State agencies as well as continuously monitoring their ongoing operations. Such assessment and monitoring clearly requires a system whereby data and information on the structure, governance, and staffing of these agencies, their planning, regulatory and resource development activities, and selected health systems characteristics and changes are reported at least annually by the health planning agencies to the Department in a consistent format.

The committee is heartened that a number of health systems agencies have been site assessed in connection with the Department's

review of their anticipated applications for full designation or requests for waiver allowing their conditional designation beyond 24 months. It is concerned, however, that only some rather than all agencies were site assessed prior to their full designation (or approval of waiver requests), and that there is evidence that careful, ongoing monitoring of State and local agencies is not carried out effectively in all parts of the country.

The committee is also concerned about the lack of an agency reporting system. Without such a system not only is the Department handicapped in its management and monitoring of the health planning program, but congressional committees are forced to rely on incomplete, dated, and frequently little more than hearsay information on the structure, operations, and performance of health systems and State agencies in their deliberations. It is incumbent, therefore, that the Secretary of Health, Education, and Welfare and the Director of the Office of Management and Budget ensure the swift development of reporting mechanisms that will provide needed information. In this regard, this committee wishes to call attention to its 1974 report which accompanied the original legislation.

> The committee is further aware of the appalling difficulty which the program in the Department has had in getting clearance for the reporting system and the forms to be used in it through the Department and the Office of Management and Budget.

This situation apparently has not been corrected.

TECHNICAL AMENDMENT

The Health Maintenance Organization Amendments of 1976, Public Law 94–460 provided that a health maintenance organization (HMO) could participate in Medicaid on a prepaid risk basis only if it was qualified under Title XIII of the Public Health Service Act if no more than 50 percent of its enrolled population was Medicare and Medicaid recipients. The law provided that an HMO could have up to three years to meet this requirement, provided it was making progress in enrolling non-Medicaid and Medicare enrollees. The three year period started on the date the organization entered into a prepaid risk contract with the State Medicaid agency or on the date the amendment was passed, which ever was later. For those organizations which already had contracts to cover Medicaid recipients that effectively gave them until October 8, 1979 to comply with the provision. Many of the organizations which believed they could qualify as HMOs applied to HEW for qualification. However, in the case of at least one of the HMOs HEW took 18 months to complete the qualification review process and that organization's efforts to enroll non-Medicaid individuals was severely hampered. It is now in danger of failing to meet the 50 percent requirement.

The committee proposal includes an amendment to the Social Security Act that would allow an organization three years from the time it received HEW qualification to meet the requirements of the law concerning the enrollment of non-Medicaid enrollees. This will counter any disadvantage which an organization received because of the delays in the HEW qualification process.

EFFECTIVE DATE

The committee bill provides that the amendments proposed shall take effect one year after the date of enactment except that health systems agencies, SHPDAs, and SHCCs may act to make changes in their structure and functions required by the amendments prior to that date. The changes in the membership of the HSAs and the SHCCs required by these amendments should be implemented as vacancies occur. The amendments made by section 117 take affect 180 days after the date of enactment of this act, except that if the Secretary determines that any amendment made by this section will require a State to change its laws before the State health planning and development agency can carry out its certificate of need functions, such amendments shall take effect in such State after the close of the first regular session of legislature which begins after the promulgation of the certificate of need regulations.

HEALTH PLANNING AND DISEASE PREVENTION

There are several respects in which the committee expects that this bill will expand and enhance the role of disease prevention activities (and particularly involvement in environmental, occupational, and nutritional health programs) in the health planning and implementation process.

First, the committee added the goal of containing the costs of health care delivery as a new national priority under section 102 of the bill. In the committee's view this goal is directly related to priority (8) of existing section 1502 of the Act—i.e., the prevention disease. The committee's views on the importance of disease prevention strategies for ultimate containment of health care costs are spelled out more fully in its report on H.R. 12584, the "Health Services Research, Health Statistics, and Health Care Technology Act of 1978." P.L. 95–623. Those same views underlie the committee's action in amending section 1502.

Thus, the committee intends that in implementing the new cost containment priority, the Secretary and appropriate State and area health planning agencies will focus greater attention, personnel and resources on identifying and correcting preventable diseases and conditions. In particular, such efforts should result in greater involvement existing processes for identifying and controlling indoor and outdoor environmental contaminants and for upgrading nutritional and environmental programs. Too little effort has been directed to disease prevention under the health planning legislation in the past. The committee expects that increased focus on cost containment will, among other results, help to strengthen and upgrade such efforts.

There is a second way in which this bill underscores the committee's intent to strengthen health planners' involvement in disease prevention, generally, and control of environmental contaminants, in particular. In section 114 of the bill, the committee specifically requires health systems agencies to include staff expertise in disease prevention and other public health matters. While this mandate is mitigated slightly by the phrase "to the extent feasible," this phrase is not intended as an escape

hatch for avoiding this requirement. The committee expects that disease prevention expertise (and particularly expertise in identifying and controlling environmental contaminants) will be available to each health system agency.

Finally, this same perspective should be understood as underlying other amendments to Title XV. In particular, in analyzing and quantifying health needs, personnel and resources to meet those needs, and the adequacy of existing efforts and plans to meet those needs under the amendments in section 115 of the bill, the State and area agencies should include a specific focus on disease prevention (including occupational, environmental, and nutritional health) needs and resources.

The committee recognizes that in many areas environmental, occupational and nutritional health programs are presently in existence. In such cases, it is not the committee's intent to require duplication of effort by health planning agencies. But it is not sufficient for health planners to rely exclusively on these other programs. Health planning agencies should actively be engaged in identifying problems and unmet needs in existing disease prevention programs. Planning agencies should identify the consequences to the health care system and the impact on rising costs of failure to address adequately these environmental health problems. They should serve as catalysts for action to improve public health in such circumstances.

Where adequate programs are not in place for environmental, occupational, and nutritional health, State and area health planning agencies are expected to identify these inadequacies and include within their plans measures to create or upgrade these programs.

REVISION AND EXTENSION OF ASSISTANCE FOR HEALTH RESOURCES DEVELOPMENT

The committee proposal repeals Part B of title XVI of the Public Health Service Act which provides for allotments to the States for the development of medical facilities. This program and its predecessor, the Hill-Burton program, have been enormously successful in stimulating the development of health care facilities, particularly hospitals, in the areas where they were needed. However, today there is a different environment—one in which there is not a pressing need for additional health care facilities but rather an environment where there is a need for modernization of some existing facilities and a reduction of excess capacity where overbuilding has occurred. Thus, the committee finds that there is no longer a need to use Federal dollars to stimulate the development of hospitals, particularly when the mechanism allots grant monies to the States on the basis of population for the operation of such programs.

Government grant support under Hill-Burton and title XVI construction has made up an increasingly smaller proportion of the total funds used for hospital capital investment, from approximately 14 percent in 1962 to less than 2 percent in 1975. Yet this reduction in Federal grant support has not seemed to impact on a hospital's ability to obtain capital for expansion or development. Other sources of capital have expanded rapidly. Debt financing, particularly tax exempt bonds, now provide for nearly 60 percent of the capital needs of hospi-

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tals. This availability of capital provides further evidence that direct government subsidies are no longer necessary.

The committee proposal would continue the loan and loan guarantee support although it would be targeted to priority areas, including:

(a) Modernization of medical facilities;

(b) Construction of new outpatient medical facilities;

(c) Construction of new hospitals in (1) areas which have experienced recent rapid population growth or (2) areas where merger or closure of medical facilities has resulted in a reduction in the number of hospital beds in the area; and

(d) Conversion of existing medical facilities to outpatient medical facilities or facilities for long term care.

In establishing these priorities, the committee recognizes that there will continue to be a major need for replacement and modernization of existing medical facilities. In some areas, the merger or closure of two or more existing hospitals and their replacement with a new more efficient facility which substantially reduces the number of hospital beds in the area may be preferable to modernizing old and inefficient hospital plants. Also of priority is the continued emphasis on the development of adequate outpatient medical facilities and long-term care facilities including the conversion of existing facilities to outpatient and long-term care uses.

The committee proposal strengthens section 1625 of the existing law which authorizes grants to public medical facilities for construction and modernization projects designed to eliminate or prevent imminent safety hazards or violations of life safety codes or regulations, or to avoid noncompliance with State or voluntary accreditation standards by expanding it so that nonprofit private entity is also eligible for assistance. Authorizations of $50 million for each of the next three fiscal years are provided for this purpose.

The reported bill also creates a new grant program for projects for the construction or modernization of outpatient medical facilities which are located apart from hospitals which will provide services to medically underserved populations, and for the conversion of existing facilities into outpatient medical facilities or facilities for long term care to provide services for medically underserved populations. The committee notes that limited funding for the modernization of certain outpatient facilities is available from appropriations under section 319 (migrant health centers) and 330 (community health centers) of the Public Health Service Act. One priority of this new grant program is to provide the necessary construction and modernization funds to entities which serve medically underserved populations and which receive or have received grants for operating migrant health centers or community health centers, or which have or have had National Health Service Corps personnel assigned to them.

The program, in addition to construction and modernization support, provides for the conversion of existing facilities into outpatient medical facilities or facilities for long term care to provde services for medically underserved populations. For example, parts of schools and other public buildings might adequately serve as outpatient medical facilities with minimal expenditures of funds.

The committee's intent in this program, as in the other amendments to title XVI, is to shift the focus of our health facilities development

effort away from inpatient hospital facilities to outpatient and long term care facilities. Outpatient medical facilities, as defined in title XVI and included in this new grant program, include ambulatory health centers which provide primary care services and which are independent organizations located apart from a hospital or which are affiliated with a hospital and located apart from or in the hospital. The program will provide grants to cover up to 80 percent of the cost of projects unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 percent of the costs; $15 million are authorized to be appropriated in each of the next three fiscal years for this purpose.

CONFORMING AMENDMENTS

The reported bill contains conforming amendments which adjust provisions of title XVI to take account of the proposal that allotment grants no longer be made to States. The Secretary is required to prescribe the general manner in which he will determine the priorities among projects for assistance under the loan and loan guarantee program as well as the project grant program. Special consideration is to be given to projects for medical facilities serving areas with relatively small financial resources and medical facilities serving rural communities; modernization projects for medical facilities serving densely populated areas; projects for outpatient medical facilities that will be located in and provide services for residents of urban and rural poverty areas; projects designed to eliminate or prevent safety hazards or avoid noncompliance with licensure or accreditation standards; and projects for medical facilities which will provide comprehensive health care including outpatient and preventive care as well as hospitalization.

The conforming amendments also provide specifications for the application to be submitted for loan and loan guarantee or grant support under title XVI. These provisions are identical to those required as part of the approval of projects under existing section 1604.

The committee bill extends the provisions of title XVI concerning assurances given by entities receiving financial assistance under this title or under title VI of the Public Health Service Act that they will make their services available to all persons residing or employed in the area served by the facility and make available a reasonable volume of services to persons unable to pay for them. The Secretary is required to issue regulations specifying the manner in which facilities are to comply with their community service and charity care assurances. In addition, the Secretary is required to collect information from each facility on a periodic basis which will enable him to determine whether or not an entity is actually in compliance with these assurances.

The committee notes that despite the explicit language of the current law, the Secretary has not yet issued any final regulations or begun to collect any assurance data. It is the intent of the committee that the Secretary carry out these requirements as expediously as possible.

A related section of the reported bill deals with enforcement of these assurances. It provides that the Secretary shall investigate complaints regarding noncompliance brought to the attention of the Department, as well as periodically examine the Department's own

initiatives. The reported bill has a provision that would require the Secretary to report all findings of noncompliance to the appropriate HSA and SHPDA.

The committee notes that the Secretary has not promulgated final regulations implementing the existing enforcement provisions. The Committee heard testimony that some assisted facilities are not in compliance with their assurances. The committee wishes to reaffirm its intention that the assurances be vigorously enforced so that a facility constructed or modernized with the aid of Federal funds will, in fact, be available to all members of the community in which the facility is located, including (consistent with the facility's financial capability) persons unable to pay.

The committee believes that widespread compliance is prompted by greater community understanding of the assurances. Accordingly, the Secretary is required to report promptly any findings of noncompliance to the appropriate health planning agency. It is expected that this information would be useful to a HSA or SHPDA as part of its project review or appropriateness review functions, in its determinations of whether or not the services of that facility are accessible to the residents of the area. However, the committee does not expect an HSA to become involved in compliance monitoring or enforcement activities related to the implementation of this provision.

TECHNICAL AMENDMENTS

The reported bill contains a number of technical amendments. One amends section 1602 of the Act to authorize the Secretary to take the necessary action for recovery in the case of a default on a health care facility loan guarantee. Under current law, while the government may have a legal responsibility to seek recovery, no authority is given to effect such recovery. For example, the Secretary lacks the authority to take over the ownership and operation of a project, or even to incur such expenses as closing up and protecting project facilities. This defect in the current law has resulted in the Government being unable to collect even partial compensation for a project in default.

The committee proposal includes a provision which would allow the Secretary to take such action as may be necessary to prevent a default on a loan made or guaranteed under Title XVI or under Title VI, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such loan, and for other purposes. Any expenditure made under this provision on behalf of the medical facilities shall be made under such terms and conditions as the Secretary shall provide including the implementation of such organizational, operational, and financial reforms as the Secretary determines are appropriate and the disclosure of such financial and other information as the Secretary may require. It is the committee's intent in adopting this section that the Secretary have increased flexibility in managing the loans which have been made or guaranteed. However, this amendment is not designed to extend the life of projects which have little prospect of remaining solvent. It is the committee's intent that

the Secretary use his authority only for projects where he finds that the action taken has a reasonable chance in preventing default.

The bill provides that the amendments made to these sections of title XVI shall take effect October 1, 1979.

PROGRAM TO ASSIST AND ENCOURAGE THE DISCONTINUANCE OF UNNEEDED HOSPITAL SERVICES

The committee has found that there is a surplus of short-term, general, non-federal hospital facilities and of some services in many areas of the Nation. The costs associated with developing and operating these unneeded facilities and services has contributed to the excessive increase in hospital costs. To reduce this source of hospital cost increases, the committee's bill establishes a program to provide financial assistance for the discontinuance of such facilities and services.

Assistance under the program would remove financial and other barriers to the termination of unneeded facilities and services and provide incentives for the development of alternative health services. By eliminating the recurring costs associated with these facilities and services, the program would reduce annual expenditures for hospital care in the area in which those facilities and services are provided.

The committee is particularly concerned, however, that this program not be used to terminate facilities and services (a) solely because they are unprofitable, (b) which have high costs but which are needed, or (c) which are the sole source of care for low income and minority persons. Many public hospitals are in difficult financial positions but are the only source of care for the low income and minority residents of the hospital's service area. Many urban hospitals are relocating to or establishing affiliated hospitals in suburban areas thereby reducing the availability of services in the center city. The committee does not intend for this program to provide assistance to hospitals which are providing needed services but which desire to move or shift services to more profitable locations or to eliminate unprofitable services. The program is intended to discontinue facilities and services which are not needed, and in so doing to stop the unnecessary expenditure of public and private monies for those services. The committee expects the Secretary of HEW to insure that facilities and services which are discontinued are not needed.

The committee's bill requires the Secretary of HEW to establish a program under which financial assistance and encouragement will be provided during the next 3 fiscal years for the consolidation of duplicative hospital facilities and services and the discontinuance of unneeded hospital facilities and services.

AUTHORIZATION OF PROGRAM

A hospital which was providing services on the date of enactment of this title may apply to the Secretary for several types of financial assistance.

The amount of any grant shall be determined by the Secretary. In the case of the grantee which discontinues the provision of hospital

services, the grant may be used for liquidation of the outstanding debt on the facilities of the grantee used for the provision of the services. The purpose of this support is to remove the financial barrier of outstanding debt on equipment and facilities so that a hospital may terminate all inpatient health services. Thus, the amount of the debt payment would be based upon the debt attributable to the equipment and facilities which would remain after the hospital used all available assets to satisfy all outstanding obligations. In determining the amount of the debt payment, the hospitals total outstanding financial obligation attributable to equipment and facilities would be reduced by any assets which were available to satisfy those obligations, and by the fair market value of the equipment and facilities. A grant can also cover other debt expenses resulting from the hospital's financial obligations being satisfied before due if the hospital's assets are insufficient to meet these expenses.

In the case of the grantee which is discontinuing the provision of an inpatient hospital service converts or proposes to convert a part of a hospital facility used in the provision of the discontinued service to the delivery of another health service, a grant may be used for the planning, development (including construction and acquisition of equipment), and delivery of the health service.

The grant may also be used to provide reasonable termination paid for the personnel of the grantee who will lose employment because of the discontinuance of hospital services made by the grantee, the training of such personnel, assisting such personnel and securing employment, and other costs related to the implementation of the closure or conversion. The committee proposal also would allow the Secretary to use grant funds to support other costs incurred by the grantee in discontinuing hospital services if he feels they are necessary to facilitate the closure or conversion.

Hospitals eligible for this assistance must (a) meet the definition in paragraph (1) and (7) of section 1861(e) of the Social Security Act, (b) impose charges or accept payments for services, and (c) have an average length of stay of thirty days or less in the preceding fiscal year. Federal and psychiatric hospitals are not eligible.

In considering an application for a conversion payment the Secretary must evaluate the amount of hospital costs which will be saved by the conversion as well as the cost of providing the alternative services in a part of the hospital as opposed to a free standing facility. The Secretary should evaluate whether to approve the application if the savings which would accrue from discontinuing the part of the hospital would be eliminated by the higher costs of providing the alternative service in the hospital instead of a free standard facility.

To receive financial assistance under this program a hospital must submit an application to the Secretary in such form and manner as the Secretary prescribes. An application must include the following information:

(1) a description of each service to be discontinued and, if a part of the hospital is to be converted to another use in connection with such discontinuance, a description of such part; (2) an evaluation of the impact of such discontinuance and conversion on the provision of health care in the health service area in which such service is pro-

vided; (3) an estimate of the change in applicant's costs which will result from such discontinuance and conversion; and (4) such other information as the Secretary may require.

The Secretary's decision to approve an application for financial assistance is discretionary. In reviewing applications the committee expects the Secretary to work closely with the applicant and the relevant health systems agency and State planning agency to determine the best course of action for the applicant and the communities which the applicant serves. The Secretary may negotiate the terms of the application and may approve all or a part of the application. While the Secretary may approve an application submitted by a hospital which is operated for profit, the committee expects the Secretary to evaluate carefully all aspects of the application to assure that it complies with all requirements and meets the priorities of the program.

The committee wishes to reemphasize that the purpose of the program is to reduce total hospital expenditures by eliminating unneeded hospital services and facilities. A recent study done for HEW indicates that the greatest cost savings result from the discontinuance of entire hospitals as opposed to a service unit or a part of a hospital. The committee expects the Secretary to place the highest priority on applications which are for assistance to discontinue entire hospitals.

If the Secretary determines that the best interests of the patients, the employees, the associated professionals and the hospital require the hospital to discontinue facilities and services over an extended period of time, the Secretary may approve an application under which the hospital will phase out the service or services to be discontinued.

The committee expects that a hospital will develop its application with the assistance of and in coordination with the health systems agency (HSA) for the health service area in which the hospital is located. When the application is filed with the Secretary it also should be submitted to the HSA for formal agency review. The HSA will determine the need for the service or services proposed to be discontinued or for the part of the hospital to be converted and the need for each service which will be provided as a result of the conversion and will make a recommendation to the State Health Planning and Development Agency (State Agency) for the State in which the hospital is located as to whether the Secretary should approve the application.

The State Agency will consider the recommendation of the HSA and then make its recommendation to the Secretary respecting the approval by the Secretary of the application. The State Agency's recommendation will be based upon the need for the service or services proposed to be discontinued or for the part of the hospital to be converted and the need for each service which will be provided as a result of the conversion as well as any other criteria which the Secretary may prescribe. The State Agency must also forward to the Secretary the recommendations of the HSA. The committee expects that the HSA and the State Agency will carry out their responsibilities under this program under the same procedures which those agencies use in acting on a request for a certificate of need. Those procedures must ensure that all persons who will be affected by the discontinuance of services will receive notice of the application and that persons directly affected will have an opportunity to appear personally at a hearing or submit written testimony to the agency.

In considering an application of a hospital the Secretary will consider the recommendations of the State Agency and the HSA and give priority to applications which meet two tests. The application must, first, assist the HSA and the State Agency in meeting the goals of their health systems plan and State health plan as to the proper supply and availability of short-term, general, non-Federal inpatient hospital services, and second, result in the greatest reduction in hospital revenues within the health service area. The Secretary may not approve an application which a State Agency recommends not be approved.

The committee expects that the Secretary will require at least two assurances from the responsible officials of the hospital, the HSA and the State Agency. Those assurances are, first, that the service or services to be discontinued are unnecessary and, second, that there are no current or foreseeable reasons for the HSA or State Agency to include in the health systems plan or State health plan or to approve a certificate of need for similar services for the same area served by the hospital.

The Secretary of HEW may not approve an application unless the Secretary of Labor has reviewed the application and notified the Secretary of HEW that the applicant has provided satisfactory assurance that the applicant will implement fair and equitable arrangements for the protection of the interests of employees who will be affected by the discontinuance of inpatient health services.

The bill provides for an exception if the Secretary of Labor has not completed his review within 90 days from the date of receipt of the application or 120 days from date of receipt if the Secretary of Labor has prescribed the circumstances under which the review will require at least 120 days. In such cases the Secretary of Health, Education, and Welfare shall review the application to determine if the applicant has provided satisfactory assurances that the applicnt will implement fair and equitable arrangements for the protection of the interests of the applicant's employees.

The committee recognizes that arrangements for the protection of employees will vary depending upon the type of services to be discontinued and the location of the hospital. Arrangements would include, where appropriate, payment of reasonable termination pay, provision of retraining, and provision for priorities in reemployment by the applicant.

The Secretary of Labor would prescribe, by regulation after consultation with the Secretary of HEW, guidelines for arrangements for the protection of the interest of employees. The Secretary of HEW would prescribe procedures for the referral to a review by the Secretary of Labor of applications submitted under this program. The committee expects that all regulations would be developed during the six month period preceding the establishment of the program. These guidelines would recognize that the arrangements for the protection of employees will vary with each hospital's application. They also would outline (a) the issues which the hospital should address and the procedures which the hospital should follow in developing their arrangements, and (b) the role of the Department of Labor in assisting the hospitals and employees and in reviewing the arrangements developed by the hospital.

The committee proposal authorizes appropriations of $50 million for the fiscal year ending September 30, 1980 and $75 million for each of the fiscal years ending September 30, 1981 and $100 million for fiscal year 1982.

If a hospital has discontinued all inpatient health services or has converted a part of its facility under an application under this program and if that hospital or its successor applies for a grant under section 330 of the Public Health Service Act (Community Health Centers) or for any other Federal assistance for the development and delivery of ambulatory health services, the Secretary would give special consideration to those applications. The committee's intent is to assure that communities which have inpatient health services discontinued and which need ambulatory health services receive special consideration: however, the Secretary of HEW may not waive any of the requirements of section 330 of the Public Health Service Act in giving special consideration to such an application.

STUDY

The Secretary is required to study the applications approved under this program during fiscal years 1980 and 1981 to determine their effect on the elimination of unneeded hospital facilities and services. The Secretary will report the results of the Department's study to Congress together with the Department's recommendation for any revisions in the program, including any revision in the authorizations for the program no later than January 1, 1982.

VIII. Program Oversight

The committee's principal oversight activities with respect to this program have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of the legislative authorities for the program. Legislative hearings on the program were conducted in January and February 1978 (Serial Numbers 95–93 and 95–94) and in March 1979, and the findings are discussed in this report as the proposed legislation is designed to respond to the subcommittee's findings. In addition, hearings were held before the Subcommittee on Health and the Environment on the National Health Planning Guidelines on October 19, 1977 (Serial Number 95–53). The committee has not received oversight findings with respect to this program from the Subcommittee on Oversight and Investigations or from the Committee on Government Operations.

IX. Inflation Impact Statement

The committee anticipates that the enactment of H.R. 3917 will have a positive impact on inflation in the health care field by promoting effective health planning including provisions whereby duplication of health care services and resources are prevented and excess hospital capacity is identified and reduced. The health planning agencies established under Title XV of the Public Health Service Act are central to any cost containment activities undertaken in this Nation.

Through the implementation of State certificate of need programs, the conduct of section 1122 capital expenditure reviews, and the exam-

ination of existing institutional health services to determine their appropriateness, the planning system should move to increase the efficiency of the health care delivery system and prevent unneeded and duplicative health services and facilities from being offered or developed thus helping to moderate rapidly rising health care costs.

X. Congressional Budget Office Cost Estimate

A cost estimate was requested on H.R. 3917 when it was ordered reported from the Committee on Interstate and Foreign Commerce and the Congressional Budget Office has provided the following information:

Congressional Budget Office,
U.S. Congress,
Washington, D.C., May 15, 1979.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.

Dear Mr. Chairman: Pursuant to section 403 of the Congressional Budget Act, the Congressional Budget Office has prepared the attached cost estimate for H.R. 3917, the Health Planning and Resources Development Amendments of 1979.

Should the committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

Alice M. Rivlin, *Director.*

Congressional Budget Office Cost Estimate

May 15, 1979.

1. Bill No.: H.R. 3917.

2. Bill title: Health Planning Amendments and Resources Development of 1979.

3. Bill status: As ordered reported by the House Committee on Interstate and Foreign Commerce on May 9, 1979.

4. Bill purpose: The purpose of this bill is to authorize appropriations for Titles XV, National Health Planning and Development, and XVI, Health Resources Development, of Public Health Service Act. Authorizations are for fiscal years 1980–1982.

Title XV established national guidelines for health planning through the creation of health service areas, health systems agencies, and statewide health planning and development agencies. H.R. 3917 makes a number of amendments of the title in such procedural and technical areas as designation of health systems areas, certificate of need programs, confidentiality requirements, certification limits, and designation of health systems agencies. The bill also authorizes appropriations for health planning grants, state health planning and development agencies, rate regulation programs, and centers for health planning.

Title XVI continues the authority of the hospital loan and loan guarantee program, and the grant program for area health services development. Project grants to eliminate safety hazards or avoid non-

compliance with accreditation standards are also authorized. And, finally, a grant program to encourage the reduction of excess hospital capacity is authorized.

5. Cost estimate (by fiscal years, in millions of dollars):

	1980	1981	1982	1983	1984
Authorization level:					
Grants to States for reduction of excess hospital capacity (1528–c)	4.0	4.0	4.0	----	----
Planning grants (1516–c–1)	150.0	160.0	170.0	----	----
State health planning and development (1525–c)	35.0	37.0	39.0	----	----
Rate regulation (1526–e)	6.0	7.0	8.0	----	----
Centers for health planning (1534–d)	10.0	11.0	12.0	----	----
Area health services development funds (1640–d)	25.0	40.0	50.0	----	----
Construction and modernization grants:					
Facility standards compliance (1625–a–3)	50.0	50.0	50.0	----	----
Outpatient facilities (1625–b–3)	15.0	15.0	15.0	----	----
Incentive payments for reduction of excess capacity (1643)	50.0	75.0	100.0	----	----
Total	345.0	399.0	448.0	----	----
Estimated outlays:					
Grants to States for reduction of excess hospital capacity (1528–c)	.4	1.2	2.8	3.6	2.8
Planning grants (1516–c–1)	54.0	153.6	163.6	108.8	----
State health planning and development (1525–c)	8.8	35.5	37.5	29.2	----
Rate regulation (1526–e)	2.4	6.4	7.4	4.8	----
Centers for health planning (1534–d)	3.8	8.7	11.2	7.3	2.0
Area health services development funds (1640–d)	9.5	26.4	40.0	28.6	8.0
Construction and modernization grants:					
Facility standards compliance (1625–a–3)	7.5	30.0	50.0	42.5	20.0
Outpatient facilities (1625–b–3)	2.2	9.0	15.0	12.8	6.0
Incentive payments for reduction of excess capacity (1643)	5.0	17.5	45.0	65.0	62.5
Total	93.6	286.3	372.5	302.6	101.3

The costs of this bill fall within budget function 550. The relevant section numbers of the Public Health Service Act appear in parentheses.

6. Basis of estimate: Outlays are based on historical expenditure rates for these programs. It was assumed that authorization levels, which are as stated in the bill, will be fully appropriated at the beginning of each fiscal year.

The provisions and amendments covering the Loan and Loan Guarantee Program (1622) are estimated to create no additional federal costs. No loan guarantees or interest subsidies have been made by the program since fiscal year 1976 nor does the Administration expect the program to renew its activities. Although the bill also makes a number of technical amendments to Titles XV and XVI, they are estimated to create no additional federal costs.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Eric Wedum.

10. Estimate approved by:

JAMES L. BLUM.
Assistant Director for Budget Analysis.

XI. AGENCY REPORT

Agency reports were requested on H.R. 3041, a similar predecessor to H.R. 3917, from the Office of Management and Budget and the Department of Health, Education, and Welfare, but to date no reports have been received.

On March 15, 1979, the Department of Health, Education, and Welfare forwarded a draft bill to extend the health planning program which was subsequently introduced by Mr. Waxman, Chairman of the Subcommittee on Health and the Environment on March 21, 1979 as H.R. 3167, "The Health Planning Amendments of 1979". In transmitting the draft bill the acting Secretary forwarded the following:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
March 15, 1979.

Hon. THOMAS P. O'NEILL,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Enclosed for consideration by the Congress is a draft bill "To amend title XV of the Public Health Service Act to revise and extend the authorities and requirements under that title for health planning, and to provide for assistance to hospitals in discontinuing inappropriate services, and for other purposes."

An appropriate health planning system is a cornerstone for the provision of quality health care and for the control of excessive health care costs. The National Health Planning and Resources Development Act of 1974 established the framework for such a system. We intend to continue our implementation of the program in this important area. The enclosed draft bill would materially assist our implementation by authorizing needed appropriations through fiscal year 1982 and by making certain improvements in current authorities.

Of particular importance in controlling unnecessary health costs is the elimination of unneeded hospital inpatient services. The draft bill would provide for demonstration grants to hospitals to assist them in eliminating inappropriate services. We estimate that this program would save more than two dollars in unnecessary costs for every dollar spent for the grants.

The Administration is not requesting an extension of the health resources development authorities in title XVI of the Public Health Service Act. There are currently more acute inpatient facilities than are needed, and most of these facilities can usually raise funds for capital expenses without federal assistance. To control ever increasing health care costs we need to discourage additional unneeded construction. We intend to assist in developing needed health resources in areas with inadequate health care systems through such activities as the National Health Service Corps, community health centers, and health maintenance organizations.

A table of appropriation authorizations appears at Tab A, and a summary of the draft bill at Tab B.

We urge that the Congress give the draft bill its prompt and favorable consideration.

The Office of Management and Budget advises that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

HALE CHAMPION,
Acting Secretary.

Enclosures.

XII. Section-by-Section Analysis

The purpose of this bill is to amend Titles XV and XVI of the Public Health Service Act to revise and extend the authorities and requirements under those Titles for health planning and resources development.

TITLE I—REVISION OF THE HEALTH PLANNING AUTHORITY

Section 101. Revision and reporting on the National Guidelines for Health Planning

Section 101(a)(1) requires the Secretary of the Department of Health, Education and Welfare to review the goals and standards established as part of the National Guidelines for Health Planning on an annual basis. In carrying out the review, the plans developed at the state and area wide levels should be reviewed and used as a basis for revising existing or developing new goals or standards. The Secretary is also required to collect data to determine whether the health care delivery systems are changing to meet the standards and goals included in the Guidelines and the resources required to meet them. The Secretary shall rely on the health systems agencies, the State health planning and development agencies, and other entities to assemble and report such data. This section also requires that the Secretary periodically make public a statement about the degree to which we are attaining the goals and standards of the National Guidelines and the changes in resources required to meet them.

Section 101(a)(2) requires the Secretary to consult with various groups at least 45 days prior to initial publication or revision of the Guidelines.

Section 101(b) requires the health systems agency (HSA) and the State health planning and development agency (SHPDA) to report to the Secretary information which will be useful in his developing a report which describes our progress in moving towards the national goals and standards. However, data regularly collected by the Department under other provisions of law need not be reported by these agencies.

Section 102. National health priorities; National Council on Health Planning and Development

Section 102(a) adds four priorities to the national health priorities in section 1502. In addition to the priorities already contained in section 1502 it adds a priority to discontinue duplicative or unneeded services or facilities and it adds a priority for the planning agencies to adopt policies which will contain the rapidly rising costs of health care delivery, insure more appropriate use of health care services, and promote greater efficiency in the health care delivery system. Priorities are also added that relate to the appropriate placement of persons with mental health problems and assuring access to mental health services particularly on an outpatient basis.

Section 102(a) also amends section 1502(9) by adding as a priority the development and use of cost saving technology.

Section 102(b) amends section 1503(b)(1) by providing that not less than one member of the National Council on Health Planning and Development shall be an administrator of a private hospital.

Section 130. The role of competition in the allocation of health services

Section 103(a) amends section 1502 by finding that extensive coverage by health insurance, particularly of inpatient health services, and the prevailing methods of paying for health services through health insurance have: resulted in decisions respecting the use of health services being made without regard to price; diminished the effect of market forces on decisions respecting the supply of health services; and consequently encouraged duplication and excess supply. For health services such as institutional health services, for which market forces do not or will not appropriately allocate supply, HSAs and SHPDAs should take actions to allocate the supply of health services. For health services for which market forces appropriately allocate or will appropriately allocate supply, HSAs and SHPDAs should give priority to actions which would strengthen the effect of market forces.

Section 103(b) amends section 1513(a) by adding to an HSA's purposes the strengthening of the effect of market forces in cases where they can appropriately allocate the supply of health services.

Section 103(c) amends section 1532(c) requiring that HSAs, SHPDAs and SHCCs consider the effect of market forces on supply and demand in their project review activities.

Section 104. Designation of health service areas

Section 104(a) amends section 1511(b)(4) by allowing a change in health service area designation if, after a public hearing, he determines the area no longer is a geographic region appropriate for effective planning and development of health services and that the proposed revision of the boundaries would establish a region appropriate for effective planning and development and which better meets at least one other of the area designation requirements.

Section 104(b) repeals section 1511(c). This section provides that those areas designated under section 314(b) of the Public Health Service Act, which otherwise meet the requirements of section 1511, should be designated health service areas unless the Governor, upon finding that another area is a more appropriate region for effective health planning waives such requirement. This section, while appropriate for initial area designation, is not appropriate for the redesignation process.

Section 104(c) amends section 1536(a) by adding the Commonwealth of Puerto Rico to the States and territories that fall under its provisions. This requires that there be no health service area or health systems agency and permits the State health planning and development agency to perform the functions of the HSA.

Section 105. Designation of health systems agencies

Section 105(a) and (b) amend section 1515(b)(4) and section 1515(c)(2) respectively, providing that the Secretary shall give priority to any application which has been recommended for approval by a Governor and shall notify the Governor of the State in which

such entity is located upon entering into an agreement with a health systems agency. The priority required to be given to applications recommended by comprehensive health planning agencies or Regional Medical Programs is deleted.

Section 105(c) amends section 1515(c) by requiring the Secretary to provide the State health planning and development agency with an opportunity to comment upon the performance of a health systems agency. It also requires the Secretary to notify the Governor of any renewal of a health systems agency redesignation agreement.

Sections 105(d) and (g) allow the Secretary to designate an HSA for up to 36 months and set forth a process for the Secretary to terminate or not renew an agreement with an HSA if it is not complying with the law. This process requires the Secretary to consult with the Governor and the SHCC, give the HSA adequate notice of the intention to terminate or not renew the designation agreement, and provide the HSA with a reasonable opportunity for a hearing. It also requires that the Secretary consult the National Council on Health Planning and Development prior to any termination or failure to renew.

Section 105(e) provides that when a health service area is redesignated, the HSA serving that area will continue to do so unless the Secretary determines that the Agency cannot effectively carry out health planning and development activities for the area.

Section 105(f) deletes the reference to entities receiving financial assistance which can also receive technical assistance and is technical in nature.

Section 105(h) permits the secretary to impose conditions on a designation agreement if the HSA has not met the requirements of section 1512(b) relating to legal structure, staff and governing body.

Section 106. Planning grants

Section 106(a) amends section 1516 and provides that the minimum grant for a health systems agency may not be less than $200,000 in the fiscal year ending September 30, 1980, $215,000 in the fiscal year 1981, and $230,000 in succeeding years. This increasing minimum grant recognizes both the need to adjust for inflation and the need to provide funding to support the increasing responsibilities of the health systems agencies. Upon enactment agencies receiving minimum grants would be eligible for a pro rata increase to the extent that funds are appropriated for that purpose.

Section 1516 is also amended to allow the Department of Health, Education, and Welfare to match contributed non-Federal funds for both the health systems agency which receives the minimum grant, as well as those above the minimum. Funds matched in any fiscal year would be based on non-Federal funds collected in the previous fiscal year.

The existing HSA funding formula is changed to a declining per capita funding to recognize economies of scale. It provides that a health systems agency will receive $.70 per capita for its first million population, $.50 per capita for its second million population, or part thereof, and $.30 per capita for any population over two million. However, if the Secretary determines that the amount provided by

the formula is not needed by the agency, he may reduce the amount of the grant after consultation with the SHPDA.

Section 106(b) allows the Secretary to increase the funding levels of health systems agencies to recognize certain extraordinary expenses that would not be adequately covered in the amount provided by the formula. Such expenses might include the expense of staff and board member travel in large rural areas or the expense that results from a bi-state HSA having to participate in the activities of more than one State.

Section 106(c) amends section 1516(a) to require the submission to the Secretary of an HSA's budget.

Section 107. Carryover of grant funds

Section 107(a) amends section 1516(a) and provides that if the health systems agencies have unobligated funds at the end of a fiscal year, they may use those funds in the following fiscal year as long as the designation agreement remains in effect.

Section 107 (b) and (c) add the same carry-over provision for the State health planning and development agency in section 1525(a) and for those receiving grants for rate regulation under section 1526(c).

Section 108. Membership requirements

Section 108(a)(1) amends section 1512(b)(3)(C)(i) by clarifying that the requirement to include major purchasers of health care on the HSA governing body includes labor organizations. It also modifies the requirement that the consumers on the HSA be broadly representative of the area by adding the requirement that the consumers of the governing body include individuals representing the principal social, economic, linguistic, handicapped and racial populations.

Section 108(a)(2) amends section 1512(b)(3)(C)(ii) by requiring that the provider members of the HSA either be residents of or have their principal place of business in the health service area. It adds podiatrists, physician assistants, and rehabilitation facilities to the examples of providers or institutions which may be represented on the HSA governing body and adds to the categories of providers listed in section 1512(b)(3)(C)(ii) which must be represented: (1) the dean of at least one school of medicine if there is such a school in the area; and (2) other providers of health care as defined in section 1531(3). The existing law defines other providers but does not explicitly provide for their representation on an HSA governing body.

Section 108(a)(3) requires that at least one-half of the providers shall be direct providers and that at least one of them shall be persons engaged in the administration of a hospital.

Section 108(b)(1) amends section 1512(b)(3)(C)(iii) and clarifies the requirement that public elected officials and other representatives of general purpose local governments are required to be included in the membership of the health systems agency governing body. It also requires that individuals who are knowledgeable about mental health services (including services for substance abuse) be included in the governing body membership.

Section (b)(2) allows the overrepresentation of rural areas by providing that the HSA membership shall include a percentage of indi-

viduals who reside in nonmetropolitan areas which is at least equal to the percentage of residents in nonmetropolitan areas.

Section 108 (b) (3) and (c) amend section 1512(b) (3) (C) to provide that the representative of the Veterans Administration shall not be considered in determining the numerical limits of an HSA, i.e., an HSA required to have a VA representative can have a 31 member governing body.

Sections 108 (b) (3) and (c) amend section 1512(b) (3) (C) to pro- a resident of the area who is no longer a provider to be eligible for consumer membership on the board unless he has been a direct provider. The existing law requires twelve months to elapse before any such resident would be eligible for consumer membership.

Section 108(d) (2) revises the definition of provider of health care by deleting the notion of indirect provider. Deleted from the existing definition of provider are the following: (1) board members of voluntary health organizations who do not have as their primary purpose the delivery of health care, the conduct of research, or the conduct of health professional instruction; and (2) the immediate family of a provider with the exception of the provider's spouse. The income test for a provider is changed from one-tenth to one-third. Rehabilitation facilities are added to the health care facilities which are listed as examples in the definition of direct provider.

Section 108(3) amends 1512(b) (3) (C) (iv) and requires that HSA appointed subcommittees and advisory groups shall have consumer majorities.

Section 109. Governing body selection

Section 109 amends section 1512(b) (3) and requires the health systems agency to establish a process for the selection of the members of its governing body which is designed to assure broad participation in the process by residents in the area.

Section 110. Responsibilities of governing bodies

Section 110(a) amends section 1512(b) (3) (B) (i) to provide that when the health systems agency is a public regional planning body or unit of general local government, that the public board shall have responsibility for the establishment of personnel rules and practices for the staff of the agency and for the agency's budget unless such functions are specifically delegated to the governing body for health planning.

Section 110(b) amends section 1512(b) (3) (A) by providing that when a health systems agency is a public regional planning body or unit of general local government, the public governing board shall appoint the members of the governing body for health planning.

Section 110(b) also amends section 1512(b) (3) (A) to provide that when a health systems agency elects to have a governing body of more than 30 members and establishes an executive committee that has authority to take action for the board, then that executive committee shall be composed of not less than 10 members, or more than 30 members.

Section 110(c) is a conforming amendment.

Section 110(d) amends section 1512(b) by clarifying the immunity from liability for money damages for HSA board members and

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employees and extending the immunity to the HSA itself. The exception to this immunity is civil action for bodily injury to individuals or physical damages to property.

Section 111. Meetings and records

Section 111(a) amends section 1512(b)(3)(B)(viii), to provide that the health systems agency is not required to conduct in public those portions of business meetings that deal with information of a personal nature the disclosure of which would constitute a clearly unwarranted invasion of personal privacy or information relating to an agency's participation in a judicial proceeding and that records and data of a personal nature the disclosure of which would constitute a clearly unwarranted invasion of personal privacy or relating to an agency's participation in a judicial proceeding do not have to be made available to the public upon request. The law currently has very broad sunshine provisions.

Section 111(b) amends section 1522(b)(6) by requiring that the State Agency hold in public meetings to conduct its business and make its records and data available in accordance with State law.

Section 111(c) amends section 1512(b)(6) to provide that any executive committee of the agency or an entity appointed by the governing body or executive committee shall: (1) conduct its business meetings (other than parts of meetings) (that deal with information of a personal nature the disclosure of which would constitute a clearly unwarranted invasion of personal privacy or information relating to an agency's participation in a judicial proceeding) in public; (2) give adequate notice of its meetings to those persons who have requested such notice; and (3) make its records and data (other than records and data of a personal nature the disclosure of which would constitute a clearly unwarranted invasion of personal privacy or relating to an agency's participation in a judicial proceeding) available upon request to the public.

Section 112. Support and reimbursement for members of governing bodies

Section 112(a) amends section 1512(b)(3) by adding a requirement that each health systems agency have an identifiable program of providing assistance to the members of its governing body, executive committee (if any), and other committees appointed by the governing body, and shall include in such program means to define the support needs of the members and to provide its members with the support, training, and continuing education which is needed.

Section 112(b) amends section 1512(b)(3)(B)(iv) by allowing the HSA, where appropriate, to make advances to board members for the reasonable costs incurred in attending meetings of the governing body.

Section 112(c) amends section 1512(b)(2)(A) and requires that at least one member of the HSA staff shall have the responsibility of providing members of the governing body with assistance in performing their functions.

Section 113. Conflicts of interest

Section 113 amends section 1513(b(3) by providing that no member of the governing body or its subunits may vote on project reviews

that deal with an individual or entity with which such member has any substantial ownership, employment, fiduciary, contractual, creditor or consultive relationship. It also requires adequate disclosure of such conflict of interest in relationship to any matter before the HSA. Similar requirements are added to the Statewide Health Coordinating Council (SHCC) provisions.

Section 114. Staff expertise

Section 114 amends section 1512(b)(2)(A) by adding expertise in financial and economic analysis and the prevention of disease and other public health matters to the list of expertise which should be present, to the extent feasible, on a health systems agency's staff.

Section 115. Health plan requirements

Section 115(a) amends section 1524(c)(1) requiring that the Statewide Health Coordinating Council (SHCC) establish a uniform format for health systems plans, thus facilitating the SHCC's role in coordinating health systems plans and preparing the State health plan.

Section 115(b) amends section 1513(b)(2) to require the HSA to develop its health systems plan in accordance with the format prescribed by the Statewide Health Coordinating Council. It also requires that the HSP include goals for mental health services developed with the assistance of persons knowledgeable about such services.

Section 115(c) amends section 1524(c)(2), section 1513(b)(2), and 1523(a)(2), requiring the State health planning and development agency to determine the health needs of the State which are state-wide after considering recommendations from the State mental health authority and similar State agencies, and requiring the health systems plans to be developed in a way which is responsive to those statewide health needs. It also requires the State agency to refer the HSP's to the State mental health authority and similar State agencies so that they can make recommendations with respect to the State health plan. If either the State agency or the SHCC do not take the action proposed in a recommendation it shall state the reasons for not taking such action.

Section 115(d) amends section 1513(b)(2) by requiring that the health systems plan include a statement of the resource requirements—personnel, facilities, and other resources—which the agency determines to be needed to meet the goals set forth in the health systems plan. The HSA may identify in such a statement any health care facility which provides inpatient health services which should undertake such changes. This section also requires that the revisions of the HSP be subject to the same public hearing requirements as the plan's establishment.

Section 115(e) amends section 1513(b)(3) by requiring that the annual implementation plan include a statement of resource requirements needed to meet the objects of the annual implementation plan. The HSA may identify in such a statement any health care facility which provides inpatient health services which should undertake such changes. This section also adds requirements that the health systems agency assure that the public has had adequate input into the development and revision of the annual implementation plan. These requirements are identical to the publication and public hearing provi-

sions required of the HSA in the adoption and revision of the health systems plan.

Section 115(f) repeals section 1513(b)(4) which requires the agency to develop and publish specific plans and projects for achieving the objectives established in the AIP. If the HSA is a public entity the planning body or unit of local government shall be given a reasonable opportunity to comment on the proposed plan and propose additions to or other revisions in it. Any proposed changes not included in the plan shall be appended to it. A provision is added to clarify that the development of an HSP or AIP in an area that includes an area under the jurisdiction of an Indian tribe or an Alaskan native village does not affect the authority of the tribe or village to establish and carry out a health plan for the Indian health programs under its jurisdiction and if a plan is developed, it shall be included in the HSP.

Section 115(g) deletes the existing requirement in 1513(b)(2) that the goals of the health systems plan are to be "consistent with" the National Guidlines for Health Planning. This makes it clear that the HSA can establish goals that are different from the National Guidelines in order to be responsive the the unique needs and resources of its area. However, the section requires that if the goals contained in the HSP are not consistent with the National Guidelines, the HSA shall provide the SHPDA and the SHCC with a detailed statement of the reasons for the inconsistency. If the HSA is a public entity the planning body or unit of local government shall be given a reasonable opportunity to comment on the proposed plan and propose additions to or other revisions in it. Any proposed changes not included in the plan shall be appended to it.

Section 115(h) amends section 1524(c)(2) by providing that the State health plan approved by the SHCC shall be the State health plan for the State unless within 60 days after its approval, the Governor disapproves the plan because it does not effectively meet the established statewide health needs. In doing so, the Governor shall make public a detailed statement on the basis for his determination that the plan does not meet statewide health needs and shall specify the changes in the plan which are needed. In developing the goals for mental health services, the SHCC may seek the advice of persons knowledgeable about such services.

Section 115(i) amends section 1513(b)(2), 1523(a)(2) and 1524(c)(2)(A) to require health plans to be reviewed at least biennially. Existing law requires annual review.

Section 115(j) requires that plans developed under section 303(a) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 or section 409(e) of the Drug Abuse Office and Treatment Act of 1972 to be consistent with the State health plan.

Section 115(k) amends provisions of the Community Mental Health Centers Act to delete the State health plan requirements under section 237. It also requires the program for community mental health centers established pursuant to section 237 and the plan developed pursuant to 314(g)(2)(D)(iv) of the Public Health Service Act be consistent

with the State health plan. The State mental health authority is authorized to designate an advisory council in carrying out its functions including its participation in the development of the State health plan.

Section 116. Criteria and procedures for reviews

Sections 116(a) and (b) amend section 1532 by requiring that in the conduct of review of plans or applications for Federal funds, that the SHCC shall, to the extent appropriate, use the procedures and criteria that apply to other reviews under Title XV listed in section 1532.

Section 116(c) requires that the HSA, the State health planning and development agency and the SHCC work together in developing criteria and procedures for review.

Section 116(d) amends section 1532(c)(6) by requiring that in adopting criteria the planning agencies shall consider, in the case of health services proposed to be provided, the effect of the proposed services on the clinical needs of health professional training programs, the extent to which such programs will have access to these services if they are to be available in a limited number of facilities, and the extent to which such services will be accessible to all the residents of the area to be served by the services.

Section 116(e) amends section 1532(c) by adding additional criteria to the list provided for health systems agency and State agency consideration in developing their own criteria. This would require that in the case of health services or facilities proposed to be provided, the efficiency and apropriateness of the use of existing services and facilities similar to those proposed be considered in the review process.

Section 116(f) amends section 1532(a) requiring the Secretary to annually review the regulations promulgated under section 1532 and provide an opportunity for planning agencies to comment on them. The Secretary shall seek comments on any revisions at least 45 days before initial publication of these revisions.

Section 116(g) amends section 1532(b)(3) and (b)(10) requiring the planning agency to develop procedures that assure that requests for information are limited to only that information which is necessary to perform the review and to allow an applicant to designate data which he believes should not be released to the public and to submit such data separately. If the agency proposes to release such data, it shall notify the applicant at least 30 days before the release. This section would also provide that the agency's procedures assure that the general public have access to all written materials "essential" (rather than "pertinent" under existing law) to a review.

Section 117. Certificate of need

Section 117(a) amends part C of Title XV by adding a new section entitled "Certificate of Need Program."

Section 1527(a)(1) requires that a certificate of need program provide for the review and determination of need for major medical equipment, institutional health services, and capital expenditures.

Section 1527(a)(2) requires that the program shall provide that only those equipment, services, and capital expenditures found to be needed shall be acquired, offered developed or obligated.

Section 1527(a)(3) provides that after a certificate of need is issued an annual review shall be conducted of the progress being made in making the equipment, expenditure or service for which the certificate of need was issued available for use, and if it is determined that the holder of the certificate is not meeting the approved timetable and is not making a good faith effort to meet it, the certificate shall be withdrawn.

Section 1527(a)(4) requires that a certificate of need shall specify the maximum amount of the capital expenditure which may be obligated for the project approved under the certificate of need. It also requires that the program prescribe the extent of additional review required of a project that exceeds the maximum capital expenditure approved.

Section 1527(a)(5) requires that a certificate of need program provide any applicant who is dissatisfied with the decision made under the program with an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies.

Section 1527(a)(6) requires that decisions of the State agency under the certificate of need program not be inconsistent with the State health plan. It also requires that a certificate of need be issued by the State agency solely on the basis of the record established in the administrative proceedings held with respect to the application for such certificate.

Section 1527(a)(7) allows the reviews to be conducted in such a manner that batching of applications can occur with comparisons being made among applications.

Section 1527(a)(8) requires that a certificate of need application shall be considered approved unless the review is completed within 90 days or such additional time on which the applicant and the agency can agree; or such additional time as prescribed in State law in cases in which a request is made to the State Agency for a hearing under section 1532(b)(8) or the State batches applications. It would allow a State to delay the beginning of a review or to suspend a review when the applicant has been cited by the Secretary of HEW for violations of the Civil Rights Act of 1964.

Section 1527(b)(1–6) requires a State to exempt from its certificate of need program the development of new institutional health services, the acquisition of major medical equipment and the obligation of capital expenditures of (1) a health maintenance organization, (2) any other provider of health care which provides ambulatory and inpatient health services on a prepaid basis if at least 75 percent of the patients who use the service or equipment which is exempt are enrollees of the organization or provider, and (3) any other provider who has entered into agreements to serve enrollees of an HMO or other providers (described in (2) above) if at least 75 percent of the annual revenues from the service, equipment or expenditures are derived from such agreements.

If in any year an exempt HMO or provider fails to meet the 75 percent patient or revenue requirement, the State shall prohibit

the HMO or provider from using the service, equipment or expenditure to provide services to individuals other than those enrolled on a prepaid basis with the HMO or provider (described in (2) above). Notice shall be provided to the Secretary and the State Medicaid agency that the provider is prohibited from using the service, equipment or expenditure to provide services to individuals who are entitled to benefits under Title XVIII and XIX of the Social Security Act unless individuals are enrolled on a prepaid basis with an HMO or provider (described in (2) above).

Section 1527(b)(7) provides that a certificate of need program may apply to an HMO only to the extent it is not exempt and then only to the acquisition of major medical equipment, the offering of institutional health service and the obligation of capital expenditures as set forth in Title XV.

Section 1527(c) requires that in reviewing an application of an osteopathic or allopathic facility for a certificate of need, the planning agency shall consider the need of and availability for services and facilities for osteopathic and allopathic physicians and their patients and consider the impact of the application on institutional training programs.

Section 1527(d) requires that an application for a certificate of need shall be approved if it is required to eliminate or prevent imminent safety hazards or comply with licensure or accreditation standards but only to the extent that the capital expenditure is required to eliminate or prevent such hazards or to comply with such standards.

Section 1527(e) excludes from required certificate of need coverage the acquisition of major medical equipment that is not owned or located in a health care facility unless that equipment will be used to provide services for inpatients of a hospital. Any person who plans to acquire such major medical equipment shall notify the SHPDA of such plans so that the agency can determine if the acquisition requires review.

Section 1527(f) requires that in granting certificates of need, the State agency shall take into account the recommendations made by health systems agencies within the State.

Section 117(b)(1) amends section 1523(a)(4)(B) by making conforming changes to section 1527 and the coverage of a certificate of need program to include capital expenditures, and major medical equipment.

Section 117(b)(2) provides that a certificate of need program for a State shall not be found satisfactory to the Secretary unless each determination of need within the State is made by the State agency solely on the basis of its review conducted in accordance with the procedures and criteria it has adopted in accordance with this Title and regulations promulgated under it.

Section 117(b)(3)(A) amends section 1531 by providing definitions for the terms "capital expenditure" and "major medical equipment." Included in the definitions is an expenditure threshold which may be adjusted to reflect annual changes in the composite construction cost index maintained by the Department of Commerce.

Section 117(b)(3)(B) modifies the definition of institutional health services in section 1531(5) and results in a change in the mandated coverage under a satisfactory certificate of need program to provide

that health maintenance organizations shall be subject to the same coverage requirements as other health care facilities. As the definition is currently written, a health maintenance organization is subject to broader coverage requirements than other facilities or organizations.

Section 117(b)(4) amends section 1522(b)(13) to allow States to use an appeals mechanism which is consistent with the State law governing the practices and procedures of administrative agencies. If there is no such State law the review must be made by other than the SHPDA.

Section 117(c) amends section 1531(5) by adding rehabilitation facilities to the definition of institutional health services and defining the term rehabilitation facility for purposes of Title XV.

Section 117(d) amends section 1532(c)(8) to provide for the consideration of the special needs and circumstances of providers or ambulatory and inpatient health services to enrollees on a prepaid basis.

Section 117(e) requires that the Secretary of Health, Education, and Welfare promulgate such regulations as may be necessary to enable the States to establish certificate of need programs which meet the requirements of section 1527 and other amendments within 180 days.

Section 118. Appropriateness review

Section 118(a) amends section 1513(g)(1) and section 1523(a)(6) and requires that the health systems agency and the State health planning and development agency review at least those institutional health services which are offered in the area and which have been designated by the Secretary for appropriateness review. It also adds home health services to the services to be included in appropriafeness review. The existing statute requires that *all* institutional health services offered in an area be reviewed every five years.

Section 118(b) adds a new section 1528 authorizing grants to States for the purpose of demonstrating the effectiveness of alternative means for reducing excess hospital capacity in a way that provides the greatest savings in the cost of health care delivery. Four million dollars is authorized for each of the next three years.

Section 119. Review and approval of proposed uses of Federal funds

Section 119(a) amends section 1524(c)(6) by requiring the SHCC to review any application submitted to the Secretary by the State for a grant or contract (either project or formula) awarded under the Public Health Service Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and section 409 of the Drug Abuse Office and Treatment Act for projects in more than one health service area. The current law requires the Statewide Health Coordinating Council to review only formula grants under these Acts.

If the SHCC recommends disapproval the Secretary may not make Federal funds available if he finds that the application is not in conformity with the State health plan. The governor shall be given 30 days to submit a revised plan or application.

Section 119(b) amends section 1513(e)(1)(A)(i) by deleting the requirements that health systems agencies review and approve proposed uses of Federal funds awarded to a State for projects in more than one health service area. The amendments also provides for the

uniform treatment of research or training grants or contracts. Health systems agencies shall not review and approve or disapprove the proposed uses of the funds for grants or contracts for research and training unless the grant or contract is to be used to support the development of health resources which in the case of grants or contracts for training, would make a significant change in health services available in the area or which, in case of grants or contracts for research, would significantly change the delivery of health service, or the distribution or extent of health resources, available to persons in the health service area other than those who are participants in such research. The amendment also provides that when a State is to make a grant or contract in a health service area from funds received under the covered Acts, the Governor of the State shall allow health systems agencies 60 days to review the proposed use of those funds in its area and approve or disapprove such use. The Governor, after taking into consideration the HSA's decision and any comments which the State health planning and development agency has developed, may make such Federal funds available for the use notwithstanding the disapproval of the health systems agency, only if the decision of the Governor is made available to the appropriate health systems agency and State health planning and development agency and contains a detailed statement of the reasons for the decision.

Section 120. Coordination of health planning with rate review

Sections 120(a) and (b) amend section 1513(d) and section 1522(b)(7)(A) by requiring that the health systems agency and the State health planning and development agency coordinate their activities with the activities of any entity of the State which reviews rates or budgets of health care facilities.

Section 120(c) amends section 1526 by providing that rate regulation grants can be made to any unit of a State which now desires to regulate rates. The existing six state limitation on the number of States which can participate is removed.

Section 121. Coordination within SMSA's and with other entities

Section 121 amends section 1513 by requiring that the HSA's which are part of a standard metropolitan statistical area develop a mechanism to coordinate their plan development and project review functions. It also provides for the sharing of data between the HSA and Indian tribes and Alaskan native villages.

Section 122. State health planning and development agencies

Sections 122(a) and (b) amend section 1521(b)(14) by requiring the Secretary to provide each HSA in a State with an opportunity to comment on a SHPDA's performance prior to the renewal of its designation agreement. It further allows the Secretary to enter into such an agreement with a state for up to 36 months, and sets forth a process for the Secretary to terminate or not renew an agreement with a SHPDA if it is not complying with the law. This process requires the Secretary to consult with the SHCC, to give the SHPDA adequate notice of the intention to terminate or not renew the designation agreement, and to provide the SHPDA with a reasonable opportunity for a hearing. The Secretary may not terminate an agreement before con-

sulting with the National Council on Health Planning and Development.

Section 122(d) amends section 1521(d) to modify the penalty in existing law if a State does not have a fully designated SHPDA by providing that no grant may be made or contract entered into with the State under the Public Health Service Act and related Acts upon the expiration of (1) the fiscal year ending September 30, 1980, (2) the regular session of the legislature of such State which begins after the promulgation of revised certificate of need regulations to implement these amendments, or (3) the sixth month after the month in which such regulations are promulgated, whichever occurs later until a full designation agreement is in effect.

Section 122(c) requires the SHPDA to prepare an inventory of the medical facilities (other than Federal health care facilities) located in the State and evaluate on an ongoing basis the physical condition of such facilities. The results shall be reported to the appropriate HSA.

Sections 122(e) and (f) are technical amendments.

Section 122(g) amends section 1521(b) allowing the Secretary to extend beyond the 36 month period prescribed by law the period of a SHPDA's conditional designation if the Secretary finds that the designated State Agency is making a good effort to comply with the requirements of section 1523.

Section 123. Statewide health coordinating council composition

Section 123(a) amends section 1524(b)(1)(A) and provides that while HSA's are to have equal representation on the SHCC, interstate HSA's are to have proportional representation (but at least one representative). It also provides that in States with more than ten HSA's, each shall be entitled to one representative. In other States, HSA's are entitled to two representatives.

Section 123(b) provides that the Governor may select the Chairman of the SHCC with the advice and consent of the State senate, or, in the case of a State with a unicameral legislature, of the State legislature.

Section 123(c) amends section 1524(b)(1)(C) to require at least one-half of the providers on the SHCC shall be direct providers and of those at least one shall be a person engaged in the administration of a health care institution.

Section 123(d) is a technical amendment.

Section 124. Authorizations

Section 124(a) amends section 1516(d)(1) (as so redesignated) and authorizes federal grant support of health systems agencies for fiscal years 1980 ($150 million), for fiscal year 1981 ($160 million), and for fiscal year 1982 ($170 million).

Section 124(b) amends section 1525(c) and provides authorization for Federal support of State health planning and development agencies for fiscal year 1980 ($35 million), for fiscal year 1981 ($37 million), and for fiscal year 1982 ($39 million).

Section 124(c) amends section 1526(e) and provides support for State rate setting in fiscal year 1980 ($6 million), for fiscal year 1981 ($7 million), and for fiscal year 1982 ($8 million).

Section 124(d) amends section 1534(d) and provides authorization for support of technical assistance activities in fiscal year 1980 ($10

million), and fiscal year 1981 ($11 million), and for fiscal year 1982 ($12 million).

Section 124(e) amends section 1640(d) and authorizes support for the area health services development fund in fiscal year 1980 ($25 million), and fiscal year 1981 ($40 million) and for fiscal year 1982 ($50 million).

Section 125. Report on effectiveness of planning law

Section 125 requires the Secretary to report to the Congress on the results of his review under section 1535 to determine the extent to which it may be demonstrated that: (A) the health of the residents in the area has been improved; (B) the accessibility, acceptability, continuity and quality of health care has been improved; and (c) increases in costs of the provision of health care have been restrained.

Section 126. Technical amendments

Section 126 amends section 1903(m)(2)(c) of the Social Security Act to allow a health maintenance organization three years from the time it is qualified to meet the requirement that at least 50 percent of an HMO's enrolled population must be made up of other than Medicare and Medicaid recipients.

Section 127. Effective date

Section 127 provides that these amendments shall take effect one year after the date of enactment of the Act except that health systems agencies, State health planning and development agencies and Statewide Health Coordinating Councils may act to make changes in their structure and functions required by the amendments prior to that date. Required membership changes can be made as vacancies occur. The amendments made by section 117 shall take effect 180 days after the date of enactment unless a change in State law is required in which case the amendments shall take effect in such State after the close of the first regular session of the legislature which begins after the promulgation of the regulations under section 117(e).

Title II—Revision of Authority for Health Resources Development

Section 201. Revision and extension of assistance

Section 201(a) repeals Part B of Title XVI "Allotments."

Section 201(b) restructures the loan and loan guarantee provisions of section 1620 to provide assistance for projects in the following priority areas:

1. Modernization of medical facilities.
2. Construction of new outpatient medical facilities.
3. Construction of new hospitals in (a) areas of rapid population or (b) areas where merger or closure of medical facilities results in a reduction of hospital beds.
4. Conversion of existing medical facilities to outpatient medical facilities or facilities for long term care.

This section also limits the 3 percent interest subsidy to loans and loan guarantees made to facilities in rural and urban poverty areas.

Section 201(c) amends section 1625 by entending the authorization for the project grant program for construction or modernization

of medical facilities by public entities and expanding it to include nonprofit private entities. A project grant program for the construction of outpatient medical facilities or facilities for long term care is established. A grant could be awarded for up to 80 percent of the cost of such projects or 100 percent of the cost of such projects located in urban or rural poverty areas. Fifteen million, 40 million and 40 million dollars are authorized for fiscal years 1980, 1981, and 1982 respectively for outpatient medical facilities. Fifty million is authorized for each of these three years for grants to public and nonprofit private entities for medical facility modernization projects.

Section 202. Conforming amendments

Section 202 contains additional conforming amendments to Title XVI.

Section 203. Technical amendments

Section 203 contains technical amendments to Title XVI. Included in these amendments is an amendment which would authorize the Secretary to take such action as may be necessary to prevent a default on a loan made or guaranteed under Title XV or XIV.

Section 204. Effective date

Section 204 provides that these amendments shall take effect on October 1, 1979 except that the amendments made by section 201(b) respecting the payment of interest subsidies apply only to loans and loan guarantees made after that date.

Title III. Program to Assist and Encourage the Discontinuance of Unneeded Hospital Service

Section 301. Authorization of program

Section 301(a) adds to Title XVI of the Public Health Service Act a new grant program to assist and encourage the discontinuance of unneeded hospital services.

Section 1641 authorizes the Secretary to establish a program under which grants and technical assistance may be provided to hospitals to assist and encourage them to discontinue the provision of unneeded hospital services.

Section 1642(a) provides that grants may be made to hospitals in operation on the date of enactment of this section.

Section 1642(b) provides that grants shall be subject to such terms and conditions as the Secretary may prescribe. The amount of a grant shall be determined by the Secretary. It may be used for: in the case of closure, the liquidation of outstanding debt; in the case of conversion, the planning, development and delivery of another service; to provide reasonable termination pay and related personnel costs; and such other costs determined necessary.

Section 1642(c) prescribes information to be contained in the grant application. It also sets forth a process by which an HSA and State Agency are to review the application and minimum criteria for the Secretary's approval of an application.

Section 1642(d) sets forth the role of the Secretary of Labor in the application review process to assure that fair and equitable arrangements for the protection of the interests of the applicant's employees have been made.

Section 1642(e) provides that section 705 relating to records and audits shall apply to grants made under this section.

Section 1642(f) defines the term hospital for purposes of this grant program.

Section 1643 authorizes $50 million in fiscal year 1980, $75 million in fiscal year 1981 and $100 million in fiscal year 1982 for purposes of this program.

Section 302. Study

Section 302 requires the Secretary of Health, Education, and Welfare to conduct a study of the effect of this program during its first two fiscal years and to report to the Congress the results by January 1, 1982.

XIII. Changes in Existing Law Made by H.R. 3917

Changes in existing law made by H.R. 3917 are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Public Health Service Act

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

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Part B—Federal-State Cooperation

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GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

Grants to States for Comprehensive State Health Planning

Sec. 314. (a) * * *

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State Mental Health Programs

(g)(1) From allotments made pursuant to paragraph (4), the Secretary shall make grants to State mental health authorities to assist them in meeting the costs of carrying out their functions under title XV of this Act and under section 237 of the Community Mental Health Centers Act and, after September 30, 1979, in meeting the costs of providing mental health services.

(2) No grant may be made under paragraph (1) unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary may require, and shall contain or be supported by assurances satisfactory to the Secretary that—

(A) the mental health services provided within the State under the grant applied for will be provided in accordance with the State health plan in effect for such State under section 1524(c);

(B) funds received under the grant applied for will (i) be used to supplement and, to the extent practical, to increase the level of non-Federal funds that would otherwise be made available for the purposes for which the grant funds are provided, and (ii) not be used to supplant such non-Federal funds;

(C) the State mental health authority will—

(i) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursements of and accounting for funds received under grants under paragraph (1);

(ii) from time to time, but not less often than annually, report to the Secretary (through a uniform national reporting system and by such categories as the Secretary may prescribe) a description of the mental health services provided in the State in the fiscal year for which the grant applied for is made and the amount of funds obligated in such fiscal year for the provision of each such category of services; and

(iii) makes such reports (in such form and containing such information as the Secretary may prescribe) as the Secretary may reasonably require, and keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness of, and to verify, such reports;

(D) the State mental health authority will—

(i) perform the duties prescribed by section 237 of the Community Mental Health Centers Act;

(ii) prescribe and provide for the enforcement of minimum standards for the maintenance and operation of mental health programs and facilities (including community mental health centers) within the State;

(iii) provide for assistance to courts and other public agencies and to appropriate private agencies to facilitate (I) screening by community mental health centers (or, if there are no such centers, other appropriate entities) of residents of the State who are being considered for inpatient care in a mental health facility to determine if such care is necessary, and (II) provision of followup care by community mental health centers (or, if there are no such centers, by other appropriate entities) for residents of the State who have been discharged from mental health facilities; and

(iv) establish and carry out a plan *which is consistent with the State health plan in effect for the State under section 1524(c) and* which—

(I) is designed to eliminate inappropriate placement in institutions of persons with mental health problems, to insure the availability of appropriate noninstitutional services for such persons, and to improve the quality of care for those with mental health problems for whom institutional care is appropriate, and

(II) shall include fair and equitable arrangements (as determined by the Secretary after consultation with the

Secretary of Labor) to protect the interests of employees affected by actions described in subclause (I), including arrangements designed to preserve employee rights and benefits and to provide training and retraining of such employees where necessary and arrangements under which maximum effort will be made to guarantee the employment of such employees.

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TITLE XV—NATIONAL HEALTH PLANNING AND DEVELOPMENT

Part A—National Guidelines for Health Planning

NATIONAL GUIDELINES FOR HEALTH PLANNING

Sec. 1501. (a) The Secretary shall, within eighteen months after the date of the enactment of this title, by regulation issue guidelines concerning national health planning policy [and shall, as he deems appropriate, by regulation revise such guidelines]. Regulations under this subsection shall be promulgated in accordance with section 553 of title 5, United States Code.

(b) The Secretary shall include in the guidelines issued under subsection (a) the following:

(1) Standards respecting the appropriate supply, distribution, and organization of health resources.

(2) A statement of national health planning goals developed after consideration of the priorities, set forth in section 1502, which goals, to the maximum extent practicable, shall be expressed in quantitative terms.

(c) [In issuing guidelines under subsection (a) the Secretary shall] *At least 45 days before the initial publication of a regulation proposing a guideline under subsection (a) or a revision under subsection (d) of such a guideline, the Secretary shall, with respect to such proposed guideline or revision,* consult with and solicit recommendations and comments from the health systems agencies designated under part B, the State health planning and development agencies designated under part C, the Statewide Health Coordinating Councils established under part C, associations and specialty societies representing medical and other health care providers, and the National Council on Health Planning and Development established by section 1503.

(d) The Secretary shall, on an annual basis, review the standards and goals included in the guidelines issued under subsection (a). In conducting such a review, the Secretary shall review the health systems plans and annual implementation plans of health systems agencies and State health plans. If the Secretary proposes to revise a guideline issued under subsection (a), he shall make such revision by regulations promulgated in accordance with section 553 of title 5, United States Code.

(e)(1) The Secretary shall collect data to determine whether the health care delivery systems meet or are changing to meet the standards and goals included in the guidelines issued under subsection (a)

and to determine the personnel, facilities, and other resources needed to meet such standards and goals. The Secretary shall prescribe (A) the manner in which such data shall be assembled and reported to the Secretary by health systems agencies. State health planning and development agencies, and other entities, and (B) the definitions which shall be used by such agencies and entities in assembling and reporting such data.

(2) The Secretary shall from the data collected under paragraph (1) periodically make public a (A) statement of the relationship between such standards and goals and the status of the supply, distribution, and organization of health resources with respect to which such standards and goals were established, and (B) summary of changes (either through additions or reductions) in resources needed to meet such standards and goals.

NATIONAL HEALTH PRIORITIES

SEC. 1502. (*a*) The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

(2) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).

(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

(4) The training and increased utilization of physician assistants, especially nurse clinicians.

(5) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of title XI of the Social Security Act.

(7) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

(9) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions and the development and use of cost saving technology.

(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

(11) The promotion of an effective energy conservation and fuel efficiency program for health service institutions to reduce the rate of growth of demand for energy.

(12) The identification and discontinuance of duplicative or unneeded services and facilities.

(13) The adoption of policies which will (A) contain the rapidly rising costs of health care delivery, (B) insure more appropriate use of health care services, and (C) promote greater efficiency in the health care delivery system.

(14) The elimination of inappropriate placement in institutions of persons with mental health problems and the improvement of the quality of care provided those with mental health problems for whom institutional care is appropriate.

(15) Assurance of access to community mental health centers and other mental health care providers for needed mental health services to emphasize the provision of outpatient as a preferable alternative to inpatient mental health services.

(b) (1) The Congress finds that extensive coverage by public and private health insurance of health services, particularly of inpatient health services, and the prevailing methods of paying for health services through health insurance have—

(A) resulted in individuals making decisions respecting their use of those health services without regard to the price of the health services,

(B) diminished the effect of the market forces of supply and demand on decisions of providers respecting the supply of those health services and the facilities through which they would be provided, and

(C) consequently encouraged duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services, and have encouraged excessive use of health services and facilities.

(2) For health services, such as inpatient health services and other institutional health services, for which the market forces of supply and demand do not or will not appropriately allocate supply because of the effects described in paragraph (1) of health insurance coverage and the methods of paying for health care under insurance, health systems agencies and State health planning and development agencies should in the exercise of their functions under such title XV take actions to allocate the supply of such services.

(3) For the health services for which the market forces of supply and demand appropriately allocate or will appropriately allocate supply, health systems agencies and State health planning and development agencies should in the performance of their functions under title XV of the Public Health Service Act give priority to actions which would strengthen the effect of such forces on the supply of such services.

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NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

SEC. 1503. (a) There is established in the Department of Health, Education, and Welfare an advisory council to be known as the National Council on Health Planning and Development (hereinafter in this section referred to as the "Council"). The Council shall advise, consult with, and make recommendations to, the Secretary with respect to (1) the development of national guidelines under section 1501, (2) the implementation and administration of this title and title XVI, and (3) an evaluation of the implications of new medical technology for the organization, delivery, and equitable distribution of health care services.

(b) (1) The Council shall be composed of fifteen members. The Chief Medical Director of the Veterans' Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary for Health of the Department of Health, Education, and Welfare shall be nonvoting ex officio members of the Council. The remaining members shall be appointed by the Secretary and shall be persons who, as a result of their training, experience, or attainments, are exceptionally well qualified to assist in carrying out the functions of the Council. Of the voting members, not less than five shall be persons who are not providers of health services, nor more than three shall be officers or employees of the Federal Government, *not less than one shall be an administrator of a private hospital*, not less than three shall be members of governing bodies of health systems agencies designated under part B, and not less than three shall be members of Statewide Health Coordinating Councils established under section 1524. The two major political parties shall have equal representation among the voting members on the Council.

(2) The term of office of voting members of the Council shall be six years, except that—

(A of the members first appointed to the Council, four shall be appointed for terms of two years and four shall be appointed for terms of four years, as designated by the Secretary at the time of appointment; and

(B) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term.

A member may serve after the expiration of his term until his successor has taken office.

(3) The chairman of the Council shall be selected by the voting members from among their number. The term of office of the chairman of the Council shall be the lesser of three years or the period remaining in his term of office as a member of the Council.

(c) (1) Except as provided in paragraph (2), the members of the Council shall each be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Council.

(2) Members of the Council who are full-time officers or employees of the United States shall receive no additional pay on account of their service on the Council.

(3) While away from their homes or regular places of business in the performance of services for the Council, members of the Council shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703(b) of title 5, United States Code.

(d) The Council may appoint, fix the pay of, and prescribe the functions of such personnel as are necessary to carry out its functions. In addition, the Council may procure the services of experts and consultants as authorized by section 3109 of title 5, United States Code, but without regard to the last sentence of such section.

(e) The provisions of section 14(a) of the Federal Advisory Committee Act shall not apply with respect to the Council.

Part B—Health Systems Agencies

HEALTH SERVICE AREAS

Sec. 1511. (a) Except as provided in section 1536, there shall be established, in accordance with this section, health service areas throughout the United States with respect to which health systems agencies shall be designated under section 1515. Each health service area shall meet the following requirements:

(1) The area shall be a geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

(2) To the extent practicable, the area shall include at least one center for the provision of highly specialized health services.

(3) The area, upon its establishment, shall have a population of not less than five hundred thousand or more than three million; except that—

(A) the population of an area may be more than three million if the area includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million, and

(B) the population of an area may—

(i) be less than five hundred thousand if the area comprises an entire State which has a population of less than five hundred thousand, or

(ii) be less than—

(I) five hundred thousand (but not less than two hundred thousand) in unusual circumstances (as determined by the Secretary), or

(II) two hundred thousand in highly unusual circumstances (as determined by the Secretary),

if the Governor of each State in which the area is located determines, with the approval of the Secretary, that the area meets the other requirements of this subsection.

(4) To the maximum extent feasible, the boundaries of the area shall be appropriately coordinated with the boundaries of areas designated under section 1152 of the Social Security Act for Pro-

fessional Standards Review Organizations, existing regional planning areas, and the State planning and administrative areas. The boundaries of a health service area shall be established so that, in the planning and development of health services to be offered within the health service area, any economic or geographic barrier to the receipt of such services in nonmetropolitan areas is taken into account. The boundaries of health service areas shall be established so as to recognize the differences in health planning and health services development needs between nonmetropolitan and metropolitan areas. Each standard metropolitan statistical area shall be entirely with the boundaries of one health service area, except that if the Governor of each State in which a standard metropolitan statistical area is located determines, with the approval of the Secretary, that in order to meet the other requirements of this subsection a health service area should contain only part of the standard metropolitan statistical area, then such statistical area shall not be required to be entirely within the boundaries of such health service area.

(b)(1) Within thirty days following the date of the enactment of this title, the Secretary shall simultaneously give to the Governor of each State written notice of the initiation of proceedings to establish health service areas throughout the United States. Each notice shall contain the following:

(A) A statement of the requirement (in subsection (a)) of the establishment of health service areas throughout the United States.

(B) A statement of the criteria prescribed by subsection (a) for health service areas and the procedures prescribed by this subsection for the designation of health service area boundaries.

(C) A request that the Governor receiving the notice (i) designate the boundaries of health service areas within his State, and, where appropriate and in cooperation with the Governors of adjoining States, designate the boundaries within his State of health service areas located both in his State and in adjoining States, and (ii) submit (in such form and manner as the Secretary shall specify) to the Secretary, within one hundred and twenty days of the date of enactment of this title, such boundary designations together with comments, submitted by the entities referred to in paragraph (2), with respect to such designations.

At the time such notice is given under this paragraph to each Governor, the Secretary shall publish as a notice in the Federal Register a statement of the giving of his notice to the Governor and the criteria and procedures contained in such notice.

(2) Each State's Governor shall in the development of boundaries for health service areas consult with and solicit the views of the chief executive officer or agency of the political subdivisions within the State, the State agency which administers or supervises the administration of the State's health planning functions under a State plan approved under section 314(a), each entity within the State which has developed a comprehensive regional metropolitan, or other local area plan or plans referred to in section 314(b), and each regional medical program established in the State under the title IX.

(3)(A) With two hundred and ten days after the date of enactment of this title, the Secretary shall publish as a notice in the Federal

Register the health service area boundary designations. The boundaries for health service areas submitted by the Governors shall, except as otherwise provided in subparagraph (B), constitute upon their publication in the Federal Register the boundaries for such health service areas.

(B) (i) If the Secretary determines that a boundary submitted to him for a health service area does not meet the requirements of subsection (a), he shall, after consultation with the Governor who submitted such boundary, make such revision in the boundary for such area (and as necessary, in the boundaries for adjoining health service areas) as may be necessary to meet such requirements and publish such revised boundary (or boundaries); and the revised boundary (or boundaries) shall upon publication in the Federal Register constitute the boundary (or boundaries) for such health service area (or areas). The Secretary shall notify the Governor of each State in which is located a health service area whose boundary is revised under this clause of the boundary revision and the reasons for such revision.

(ii) In the case of areas of the United States not included within the boundaries for health service areas submitted to the Secretary as requested under the notice under paragraph (1), the Secretary shall establish and publish in the Federal Register health service area boundaries which include such areas. The Secretary shall notify the Governor of each State in which is located a health service area the boundary for which is established under this clause of the boundaries established. In carrying out the requirement of this clause, the Secretary may make such revisions in boundaries submitted under subparagraph (A) as he determines are necessary to meet the requirement of subsection (a) for the establishment of health service areas throughout the United States.

(4) The Secretary shall review on a continuing basis and at the request of any Governor or designated health systems agency the appropriateness of the boundaries of the health service areas established under paragraph (3) and, [if he determines that a boundary for a health service area no longer meets the requirements of subsection (a), he may revise the boundaries] *if he determines, after providing reasonable opportunity for a public hearing—*

(A) that a health service area does not meet the requirement of paragraph (1) of subsection (a) relating to effective planning and development of health services, and

(B) revision of the boundaries would establish an area which meets such requirement and which better meets at least one other requirement of such subsection,

he may revise the boundaries in accordance with the procedures prescribed by paragraph (3) (B) (ii) for the establishment of boundaries of health service areas which include areas not included in boundaries submitted by the Governors. If the Secretary acts on his own initiative to revise the boundaries of any health service area, he shall consult with the Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate health systems agency or agencies designated under part B and the appropriate Statewide Health Coordinating Council established under part C. A request for boundary revision shall be made only after consultation with the

Governor of the appropriate State or States, the entities referred to in paragraph (2), the appropriate designated health systems agencies, and the appropriate established Statewide Health Coordinating Council and shall include the comments concerning the revision made by the entities consulted in requesting the revision.

(5) Within one year after the date of the enactment of this title the Secretary shall complete the procedures for the initial establishment of the boundaries of health service areas which (except as provided in section 1536) include the geographic area of all the States.

[(c) Notwithstanding any other requirement of this section, an area—

[(1) for which has been developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 314(b), and

[(2) which otherwise meets the requirements of subsection (a), shall be designated by the Secretary as a health service area unless the Governor of any State in which such area is located, upon a finding that another area is a more appropriate region for the effective planning and development of health resources, waives such requirement.]

HEALTH SYSTEMS AGENCIES

SEC. 1512. (a) DEFINITION.—For purposes of this title, the term "health systems agency" means an entity which is organized and operated in the manner described in subsection (b) and which is capable, as determined by the Secretary, of performing each of the functions described in section 1513. The Secretary shall by regulation establish standards and criteria for the requirements of subsection (b) and section 1513.

(b)(1) LEGAL STRUCTURE.—A health systems agency for a health service area shall be—

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before the date of enactment of this subsection) to carry out health planning and review functions such as those described in section 1513, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government in the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

(2) STAFF.—

(A) EXPERTISE.—A health systems agency shall have a staff which provides the agency with expertise in at least the following: (i) Administration, (ii) the gathering and analysis of data, (iii)

health planning, [and] (iv) development and use of health resources, (*v*) *to the extent feasible, financial and economic analysis, and* (*vi*) *to the extent feasible, prevention of disease and other public health matters.* The functions of planning and of development of health resources shall be conducted by staffs with skills appropriate to each function. *At least one member of the staff shall be designated to have the responsibility of providing the members of the governing body of an agency with such information and technical assistance as they may require to effectively perform their functions.*

(B) SIZE AND EMPLOYMENT.—The size of the professional staff of any health systems agency shall be not less than five, except that if the quotient of the population (rounded to the next highest one hundred thousand) of the health service area which the agency serves divided by one hundred thousand is greater than five, the minimum size of the professional staff shall be the lesser of (i) such quotient, or (ii) twenty-five. The members of the staff shall be selected, paid, promoted, and discharged in accordance with such system as the agency may establish, except that the rate of pay for any position shall not be less than the rate of pay prevailing in the health service area for similar positions in other public or private health service entities. If necessary for the performance of its functions, a health systems agency may employ consultants and may contract with individuals and entities for the provision of services. Compensation for consultants and for contracted services shall be established in accordance with standards established by regulation by the Secretary.

(3) GOVERNING BODY.—

(A) IN GENERAL.—A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, [have a governing body for health planning, which is established in accordance with subparagraph (C).] *appoint a governing body for health planning in accordance with subparagraph (C)* which shall have the responsibilities prescribed by subparagraph (B), and which [has] *shall have* exclusive authority to perform for the agency the functions described in section 1513. Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an "executive committee") composed, in accordance with subparagraph (C), of [not more than twenty-five members] *not less than ten members and of not more than thirty members* of the governing body and has delegated to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (B)(ii) as the governing body is authorized to take.

(B) RESPONSIBILITIES.—The governing body—

[(i) shall be responsible for the internal affairs of the health systems agency, including matters relating to the staff of the agency, the agency's budget, and procedures and

criteria (developed and published pursuant to section 1532) applicable to its functions under subsections (e), (f), (g), and (h) of section 1513;]

(i) shall be responsible for—

(I) the internal affairs of the health systems agency, including matters relating to the staff of the agency and the agency's budget, except that the governing body for health planning of an agency which is a public regional planning body or unit of general local goverment shall not be responsible for the establishment of personnel rules and practices for the staff of the agency or for the the agency's budget unless authorized by the planning body or unit of government, and

(II) procedures and criteria developed and published pursuant to section 1532 and applicable to its functions under subsections (e), (f), and (g) of section 1513;

(ii) shall be responsible for the establishment of the health systems plan and annual implementation plan required by section 1513(b)

(iii) shall be responsible for the approval of grants and contracts made and entered into under section 1513(c)(3);

(iv) shall be responsible for the approval of all actions taken pursuant to subsections (e), (f), *and* (g) [, and (h)] of section 1513;

(v) shall (I) issue an annual report concerning the activities of the agency, (II) include in that report the health systems plan and annual implementation plan developed by the agency, and a listing of the agency's income, expenditures, assets, and liabilities, and (III) make the report readily available to the residents of the health service area and the various communications media serving such area;

(vi) shall reimburse (*or when appropriate make advances to*) its members for their reasonable costs incurred in attending meetings of the governing body;

(vii) shall meet at least once in each calendar quarter of a year and shall meet at least two additional times in a year unless its executive committee meets at least twice in that year; and

(viii) shall (I) [conduct its business meetings in public] *hold in public meetings to conduct the business of the agency (other than any part of a meeting in which it is likely, as determined by the governing body, that information of a personal nature will be disclosed and such a disclosure would constitute a clearly unwarranted invasion of personal privacy or that information relating to the agency's participation in a judicial proceeding will be disclosed)*, (II) give adequate notice to the public of such meetings, and (III) make [its records and data] *records and data of the agency (other than personnel and medical and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy and records or data of the agency relating to its participation in a judicial proceeding)* available, upon request, to the public.

The governing body (and executive committee (if any)) of a health systems agency shall act only by vote of a majority of its members present and voting at a meeting called upon adequate notice to all of its members and at which a quorum is in attendance. A quorum for a governing body and executive committee shall be not less than one-half of its members.

(C) COMPOSITION.—The membership of the governing body and the executive committee (if any) of any agency shall meet the following requirements:

(i) A majority (but not more than 60 per centum of the members) shall be (*I*) residents of the health service area served by the entity who are consumers of health care and who are not [(nor within the twelve months preceding appointment been) providers of health care] *providers of health care and have not within the twelve months preceding appointment been direct providers of health care (as defined in section 1531(3)(A))* [and who are broadly representative of the social, economic, linguistic, and racial populations, geographic areas of the health area, and major purchasers of health care], *and (II) broadly representative of the health service area and shall include individuals representing the principal social, economic, linguistic, handicapped, and racial populations and geographic areas of the health service area and major purchasers of health care (including labor organizations) in the area.*

(ii) The remainder of the members shall be residents of, *or have their principal place of business in*, the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, optometrists, *podiatrists, physician assistants*, and other health professionals, [(II) health care institutions (particularly hospitals, long-term care facilities, substance abuse treatment facilities and health maintenance organizations, (III) health care insurers, (IV) health professional schools, and (V) the allied health professions.] *(II) hospitals and other health care institutions (such as facilities for long-term care, rehabilitation facilities, and health maintenance organizations), (III) if the health service area contains one or more accredited schools of medicine, the dean of at least one such school, (IV) health professional schools (other than schools of medicine if such schools are represented pursuant to subclause (III)), (V) the allied health professions, (VI) health care insurers, and (VII) other providers of health care as defined in section 1531(3).* Not less than [one-third] *one-half* of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 1531(3)) *and of such direct providers of health care, at least one shall be a person engaged in the administration of a hospital.*

(iii) The membership shall—

(I) include (either through consumer or provider members) public elected officials and other representatives

of [governmental authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health.] *general purpose local governments in the agency's health service area,*

(II) include (either through consumer or provider members) representatives of public and private agencies in the area concerned with health,

(III) include (through consumer and provider members) individuals who are knowledgeable about mental health services (including services for substance abuse),

[(II)] *(IV)* include a percentage of individuals who reside in nonmetropolitan areas within the health service area which percentage is *at least* equal to the percentage of residents of the area who reside in nonmetropolitan areas, and]

[(III)] *(V)* if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose, and [if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations.]

(VI) if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of section 1310), include at least one member who is representative of such organizations.

(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the representation on such subcommittee or group described in this subparagraph, *except that appointments shall be made to such subcommittees and groups in such a manner that a majority of their members shall be consumers of health care.*

A member of a governing body or other entity appointed pursuant to clause (iii)(V) shall not be considered in determining the number of members of the governing body for purposes of the numerical limit prescribed by subparagraph (A).

(D) SELECTION.—Each health systems agency shall establish a process for the selection of the members of its governing body which process, to the extent permitted by the State law applicable to the incorporation of the agency, is designed to assure that (i) such members are selected in accordance with the requirements of subparagraph (C), (ii) there is the opportunity for broad participation in such process by the residents of the health service area of the agency, and (iii) the participation of such residents will be encouraged and fa-

cilitated. Each agency shall make public such process and report it to the Secretary.

(E) SUPPORT.—Each health systems agency shall have an identifiable program of providing assistance to the members of its governing body, executive committee (if any), and any entity appointed by the governing body or executive committee in making decisions for the agency, and shall include in such program means to determine the support needs of the members and to provide for meeting those needs (including the provision of training and continuing education).

(F) CONFLICTS OF INTEREST.—No member of a governing body, executive committee, or any entity appointed by a governing body, or executive committee may, in the exercise of any function of the agency described in subsection (e), (f), or (g) of section 1513, vote on any matter before the governing body, executive committee, or any such entity respecting any individual or entity with which such member has any substantial ownership, employment, fiduciary, contractual, creditor, or consultative relationship. A governing body, executive committee, and any entity appointed by a governing body or executive committee shall require each of its members who has or has had such a relationship with an individual or entity involved in any matter before the governing body, committee, or entity to make a written disclosure of such relationship before any action is taken by the body, committee, or entity with respect to such matter in the exercise of any function of the agency described in section 1513 and to make such relationship public in any meeting in which such action is to be taken.

[(4) INDIVIDUAL LIABILITY.—No individual who, as a member or employee of a health systems agency, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.]

(4) LIABILITY.—

(A) IN GENERAL.—Except as provided in subparagraph (B)—

(i) a health systems agency shall not, by reason of the performance of any duty, function, or activity, required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if the member of the governing body of the agency or employee of the agency who acted on behalf of the agency in the performance of such duty, function, or activity acted within the scope of his duty, function, or activity as such a member or employee, exercised due care, and acted without malice toward any person affected by his performance; and

(ii) no individual member of the governing body of a health systems agency or employee of a health systems agency shall,

by reason of his performance on behalf of the agency of any duty, function, or activity required of, or authorized to be undertaken by, the agency under this title, be liable for the payment of damages under any law of the United States or any State (or political subdivision of a State) if he acted within the scope of his duty, function, or acitivity as such a member or employee, exercised due care, and acted without malice toward any person affected by his performance.

(B) EXCEPTION.—Subpargaraph (A) does not apply with respect to civil actions for bodily injury to individuals or physical damages to property brought against a health systems agency or any member of the governing body of or employee of such an agency.

(5) PRIVATE CONTRIBUTIONS.—No health systems agency may accept any funds or contributions of services or facilities from any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources unless, in the case of an entity, it is an organization described in section 509(a) of the Internal Revenue Code of 1954 and is not directly engaged in the provision of health care in the health service area of the agency. For purposes of this paragraph, an entity shall not be considered to have such an interest solely on the basis of its providing (directly or indirectly) health care for its employees.

(6) OTHER REQUIREMENTS.—Each health system agency shall—

(A) provide that any executive committee of the agency and any entity appointed by the governing body or executive committee of the agency shall (i) hold in public meetings to conduct the business of the committee or entity (other than any part of a meeting in which it is likely, as determined by the executive committee or entity, that information of a personal nature will be disclosed and such disclosure would constitute a clearly unwarranted invasion of personal privacy or that information relating the agency's participation in a judicial proceeding will be disclosed), and (ii) give adequate notice of its meetings to those persons who have requested such notice;

[(A)] *(B)* make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

[(B)] *(C)* provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this title and section 1640; and

[(C)] *(D)* permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records pertinent to the disposition of amounts received from the Secretary under this title and section 1640.

(c) SUBAREA COUNCILS.—A health systems agency may establish subarea advisory councils representing parts of the agency's health

service area to advise the governing body of the agency on the performance of its functions. The composition of a subarea advisory council shall conform to the requirements of subsection (b)(3)(C).

FUNCTIONS OF HEALTH SYSTEMS AGENCIES

SEC. 1513. (a) For the purpose of—

(1) improving the health of residents of a health services area,

(2) increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

(3) restraining increases in the cost of providing them health services, [and]

(4) preventing unnecessary duplication of health resources, *and*

(5) *strengthening in accordance with section 1502(b) the effect of the market forces of supply and demand on the supply of health services*,

each health systems agency shall have as its primary responsibility provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency. To meet its primary responsibility, a health systems agency shall carry out the functions described in subsections (b) through [(h)] (*g*) of this section.

(b) In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

(1) The agency shall assemble and analyze data concerning—

(A) the status (and its determinants) of the health of the residents of its health service area,

(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

(C) the effect the area's health care delivery system has on the health of the residents of the area,

(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,

(E) the patterns of utilization of the area's health resources, and

(F) the environmental and occupational exposure factors affecting immediate and long term health conditions.

The agency shall also assemble and report to the Secretary such data (including data on the personnel, facilities, and other resources needed to meet the goals set forth in the agency's health system plan) as the Secretary may require to carry out his responsibilities under section 1501(e). The Secretary may not require the assembling and reporting of data under this paragraph which is regularly collected by any entity of the Department of Health, Education, and Welfare under a provision of law other than this title. In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and

coordinate its activities with the cooperative system provided for under section 306(e).

(2) The agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 1501, the priorities set forth in section 1502, and the data developed pursuant to paragraph (1), establish (*in accordance with the format established pursuant to section 1524(c)(1)*, [annually] *biennially* review, and amend as necessary a health systems plan (hereinafter in this title referred to as the "HSP") which shall be a detailed statement of goals (A) describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources (*including entities described in section 1532(c)(7)* of the area; [and] (C) which take into account [and is consistent with] the national guidelines for health planning policy issued by the Secretary under section 1501 respecting supply, distribution, and organization of health resources and services; *and (D) which are responsive to statewide health needs as determined by the State health planning and development agency. The HSP of the agency shall include goals for the delivery of mental health services in its health service area which goals shall be developed under a procedure under which persons (acting as an advisory group or subcommittee appointed by the agency or, if the agency requests and is authorized by order of the Secretary to use an existing group, acting as part of such a group) knowledgeable about such services (including services for substance abuse) will be consulted with respect to such goals. The HSP shall also include a statement of changes (through increases or reductions, or both) in personnel, facilities, and other resources which the agency determines are required to meet the goals set forth in the preceding sentence. The health systems agency may identify in such a statement of changes any health care facility which provides inpatient health services and which the agency determines should undertake such changes.* Before establishing *or revising* an HSP, a health systems agency shall conduct a public hearing on the proposed HSP and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish it at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed HSP, the time and place of the hearing, the place at which interested persons may consult the HSP in advance of the hearing, and the place and period during which to submit written comments to the agency on the HSP. *If the health systems agency is a public regional planning body or unit of general local government, the planning body or unit of government shall be given a reasonable opportunity to comment on the proposed HSP and to propose additions to and other revisions in it. Any such proposed additions or other revisions not included in the HSP approved by the agency shall be appended to the HSP. Each health systems agency shall*

make its HSP available to the State health planning and development agency of each State in which the health service area of the health systems agency is located for inclusion in the preliminary State health plan to be prepared under section 1523(a)(2) and, if the goals contained in the HSP are not consistent with guidelines issued by the Secretary under section 1501, it shall provide the State agency with a detailed statement of the reasons for the inconsistency between such goals and guidelines. When making such HSP available to a Statewide Health Coordinating Council under section 1524(c)(2)(A), the agency shall also report such statement to such Council.

(3) The agency shall establish, annually review, and amend, as necessary an annual implementation plan (hereinafter in this title referred to as the "AIP") which describes objectives which will achieve the goals of the HSP and priorities among the objectives. In establishing the AIP, the agency, shall give priority to those objectives which will maximally improve the health of the residents of the area, as determined on the basis of the relation of the cost of attaining such objectives to their benefits, and which are fitted to the special needs of the area. *The AIP shall include a statement of changes (through increases or reductions, or both) in personnel, facilities, and other resources which the agency determines are required to meet the objectives described pursuant to the first sentence. The health systems agency may identify in such a statement of changes any health care facility which provides inpatient health services and which the agency determines should undertake such changes. If the health systems agency is a public regional planning body or unit of general local government, the planning body or unit of government shall be given a reasonable opportuity to comment on the proposed AIP and to propose additions to and other revisions in it. Any such proposed additions or other revisions not included in the AIP approved by the agency shall be appended to the AIP. Before establishing or revising an AIP, the agency shall conduct a public hearing on the proposed AIP and shall give interested persons an opportunty to submit their views orally and in writing. Not less than thirty days prior to such hearing, the agency shall publish in at least two newspapers of general circulation throughout its health service area a notice of its consideration of the proposed AIP, the time and place of the hearing, the place at which interested persons may review the AIP in advance of the hearing, and the place and period during which to submit written comments to the agency on the AIP.*

[(4) The agency shall develop and publish specific plans and projects for achieving the objectives established in the AIP.]

(4) If a health service area includes an area under the jurisdiction of an Indian tribe or an Alaska Native Village, the establishment of an HSP and AIP under this subsection for such health service area does not affect the authority of such tribe or Village to establish and carry out a health plan for the Indian health programs in the area under its jurisdiction; and if such tribe or Village establishes such a health plan, such plan shall be included in the HSP for such health service area.

(c) A health system agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area.

(2) The agency may provide, in accordance with the priorities established in the AIP, technical assistance to individuals and public and private entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP, including assistance in meeting the requirements of the agency prescribed under section 1532(b).

(3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and nonprofit private entities and enter into contracts with individuals and public and nonprofit private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. Such grants and contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 1640. No grants or contract under this subsection may be used (A) to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary), or (B) for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program.

(d)(*1*) Each health systems agency shall coordinate its activities with—

[(1)](*A*) each Professional Standards Review Organization (designated under section 1152 of the Social Security Act),

[(2)](*B*) entities referred to in paragraphs (1) and (2) of section 204(a) of the Demonstration Cities and Metropolitan Development Act of 1966 and regional and local entities the views of which are required to be considered under regulations prescribed under section 403 of the Intergovernmental Cooperation Act of 1968 to carry out section 401(b) of such Act,

[(3)](*C*) other appropriate general or special purpose regional planning or administrative agencies, and

[(4)](*D*) any other appropriate entity,

in the health systems agency's health service area. *Each health systems agency shall also coordinate its activities with any entity of the State in which the agency is located which reviews the rates or budgets of health care facilities located in the health systems agency's health service area.* The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such

entities which alter the area's health systems will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities.

(2) Each health systems agency which has all or part of its health service area within a part of a standard metropolitan statistical area (as determined by the Office of Management and Budget) shall coordinate its activities with the activities of any other health systems agency which has any part of its health service area within such standard metropolitan statistical area. Such coordination shall be carried out in accordance with a plan approved by the Secretary which shall at least provide that each health systems agency designated for a health service area within any part of a single standard metropolitan statistical area shall review (A) each HSP and AIP for each such health service area, (B) the criteria used in accordance with section 1532 for reviews affecting any such area, and (C) each decision under certificate of need programs which affect any such area.

(3) The Secretary shall by regulation provide for the sharing of health planning data between health systems agencies and Indian tribes and Alaska Native Villages.

(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds—

(i) appropriated under this Act, the Community Mental Health Centers Act, sections 409 and 410 of the Drug Abuse Office and Treatment Act *of 1972*, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources *by any entity other than the government of a State unless such resources are solely within the health service area of such agency;* or

(ii) made available by the State in which the health service area is located (from an allotment, *contract, or grant* to the State under an Act referred to in clause (i)) for grants or contracts for the development, expansion, or support of health resources.

(B) A health systems agency shall not review and approve or disapprove the proposed use within its health service area of Federal funds appropriated for grants or contracts [under title IV, VII, or VIII of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources intended for use in the health service area or the delivery of health services] *for research or training unless the grants or contracts are to be made, entered into, or used for the development, expansion, or support of health resources which, in the case of grants or contracts for training, would make a significant change in the health services available in the health service area or which, in the case of grants or contracts for research, would significantly change the delivery of health services, or the distribution or extent of health resources, available to persons in the health service area other than those who are participants in such research.* In the case of a proposed use within the health service area of a health systems agency of Federal funds described in subparagraph (A) by an Indian tribe or intertribal Indian organization for any pro-

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gram or project which will be located within or will specifically serve—

(i) a federally-recognized Indian reservation,

(ii) any land area in Oklahoma which is held in trust by the United States for Indians or which is a restricted Indian-owned land area, or

(iii) a Native village in Alaska (as defined in section 3(c) of the Alaska Native Claims Settlement Act).

a health systems agency shall only review and comment on such proposed use.

(2) Notwithstanding any other provision of this Act or any other Act referred to in paragraph (1), the Secretary shall allow a health systems agency sixty days to make the review required by [such] paragraph (*1*) (*A*) (*ii*). If *under paragraph (1) (A) (i)* an agency disapproves a proposed use in its health service area of Federal funds described in paragraph (1), the Secretary may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Secretary shall give the appropriate State health planning and development agency an opportunity to consider the decision of the health systems agency and to submit to the Secretary its comments on the decision. The Secretary, after taking into consideration such State agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Secretary to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.

(*3*) *The Governor of a State shall allow health systems agencies sixty days to make the review by paragraph (1) (A) (ii). If under such paragraph an agency disapproves a proposed use of Federal funds in its health service area, the Governor may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency decision. In making any such review of any agency decision, the Governor shall give the State health planning and development agency an opportuntiy to consider the decision of the health systems agency and to submit to the Governor its comments on the decision. The Governor, after taking into consideration such State Agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproval of the health systems agency. Each such decision by the Governor to make funds available shall be submtited to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision.*

[(3](*4*) Each health systems agency shall provide each Indian tribe or inter-tribal Indian organization which is located within the agency's health service area information respecting the availability of the Federal funds described in the first sentence of this subsection.

(f) To assist State health planning and development agencies in carrying out their functions under paragraphs (4) and (5) of section 1523(a) each health systems agency shall review and make recommendations to the appropriate State health planning and development agency respecting the need for new institutional health services

proposed to be offered or developed in the health service area of such health systems agency.

(g)(1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) [all institutional health services offered in the health service area of the agency] *at least those institutional and home health services which are offered in the health service area of the agency and which have been designated by the Secretary by regulation for appropriateness review under this paragraph* and shall make recommendations to the State health planning and development agency designated under section 1521 for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.

(2) A health systems agency shall complete its initial review of existing institutional health services within three years after the date of the agency's designation under section 1515(c).

[(h) Each health systems agency shall annually recommend to the State health planning and development agency designated for each State in which the health systems agency's health service area is located (1) projects for the modernization, construction, and conversion of medical facilities in the agencys health service area which projects will achieve the HSP and AIP of the health systems agency, and (2) priorities among such projects.]

ASSISTANCE TO ENTITIES DESIRING TO BE DESIGNATED AS HEALTH SYSTEMS AGENCIES

SEC. 1514. The Secretary may provide all necessary technical and other nonfinancial assistance (including the preparation of prototype plans of organization and operation) to public or nonprofit private entities [(including entities presently receiving financial assistance under section 314(b) or title IX or as experimental health service delivery systems under section 304)] which—

(1) express a desire to be designated as health systems agencies, and

(2) the Secretary determines have a potential to meet the requirements of a health systems agency specified in sections 1512 and 1513,

to assist such entities in developing applications to be submitted to the Secretary under section 1515 and otherwise in preparing to meet the requirements of this part for designation as a health systems agency.

DESIGNATION OF HEALTH SYSTEMS AGENCIES

SEC. 1515. (a) At the earliest practicable date after the establishment under section 1511 of health service areas (but not later than eighteen months after the date of enactment of this title) the Secretary shall enter into agreements in accordance with this section for the designation of health systems agencies for such areas.

(b)(1) The Secretary may enter into agreements with entities under which the entities would be designated as the health systems agencies for health service areas on a conditional basis with a view to deter-

mining their ability to meet the requirements of section 1512(b), and their capacity to perform the functions prescribed by section 1513.

(2) During any period of conditional designation (which, except as otherwise provided in this paragraph, may not exceed 24 months), the Secretary may require that the entity conditionally designated meet only such of the requirements of section 1512(b) and perform only such of the functions prescribed by section 1513 as he determines such entity to be capable of meeting and performing. The Secretary may, upon application of a conditionally designated entity, extend for an additional period of not to exceed 12 months the period of such entity's conditional designation if the Secretary determines that (A) unusual circumstances exist or existed which prevent such entity from qualifying for designation under subsection (c) within 24 months of such entity's conditional designation under this subsection, (B) such extension should enable such entity to qualify for designation under subsection (c), and (C) such extension is necessary to carry out the purposes of this title. Each such determination shall be in writing and shall include a summary of the reasons for it. The number and type of such requirements and functions shall, during the period of conditional designation, be progressively increased as the entity conditionally designated becomes capable of added responsibility so that, by the end of such period, the agency may be considered for designation under subsection(c).

(3) Any agreement under which any entity is confidentially designated as a health systems agency may be terminated by such entity upon ninety days notice to the Secretary or by the Secretary upon ninety days notice to such entity.

(4) The Secretary may not enter into an agreement with any entity under paragraph (1) for conditional designation as a health systems agency for a health service area until—

(A) the entity has submitted an application for such designation which contains assurances satisfactory to the Secretary that upon completion of the period of conditional designation the applicant will be organized and operated in the manner described in section 1512(b) and will be qualified to perform, the functions prescribed by section 1513;

(B) a plan for the orderly assumption and implementation of the functions of a health systems agency has been received from the applicant and approved by the Secretary; and

(C) the Secretary has consulted with the Governor of each State in which such health service area is located and with such other State and local officials as he may deem appropriate, with respect to such designation.

In considering such applications, the Secretary shall give priority to [an] *any* application which has been recommended [for approval by each entity which has developed a plan referred to in section 314(b) for all or part of the health service area with respect to which the application was submitted, and each regional medical program established in such area under title IX] *by a Governor for approval. When the Secretary enters into an agreement with an entity under paragraph (1), the Secretary shall notify the Governor of the State in which such entity is located of such agreement.*

(c)(1)(*A*) The Secretary shall enter into an agreement with an entity for its designation as a health systems agency if, on the basis of an application under paragraph (2) (and, in the case of an entity conditionally designated, on the basis of its performance during a period of conditional designation under subsection (b) as a health systems agency for a health service area), the Secretary determines that such entity is capable of fulfilling, in a satisfactory manner, the requirements and functions of a health systems agency. Any such agreement under this subsection with an entity may be renewed in accordance with paragraph (3), shall contain such provisions respecting the requirements of sections 1512(b) and 1513 and such conditions designed to carry out the purpose of this title, as the Secretary may prescribe, and shall be for a term of not to exceed [twelve] *thirty-six* months; except that, prior to the expiration of such term, such agreement may be terminated—

[(A)](*i*) by the entity at such time and upon such notice to the Secretary as he may by regulation prescribe, or

[(B) by the Secretary, at such time and upon such notice to the entity as the Secretary may by regulation prescribe, if the Secretary determines that the entity is not complying with or effectively carrying out the provisions of such agreement.]

(*ii*) *by the Secretary if the Secretary determines, in accordance with subparagraph (B), that the entity is not complying with the provisions of such agreement.*

A designation agreement under this subsection may be terminated by the Secretary before the expiration of its term if the health service area with respect to which the agreement was entered into is revised under section 1511(b)(4) and the Secretary determines, after consultation with the Governor of each State in which the health service area (as revised) is located, that the health systems agency designated under such agreement cannot effectively carry out the agreement for the area (as revised). In terminating an agreement under the preceding sentence, the Secretary may provide that the termination not take effect before an agreement for the designation of a new agency takes effect and shall provide the agency designated under the agreement to be terminated an opportunity to terminate its affairs in a satisfactory manner.

(*B*) *Before the Secretary may terminate, under subparagraph (A)(ii), an agreement with an entity for designation as the health systems agency for a health service area, the Secretary shall—*

(*i*) *consult with the Governor and the Statewide Health Coordinating Council of each State in which is located the health service area respecting the proposed termination,*

(*ii*) *give the entity notice of the intention to terminate the agreement and in the notice specify with particularity (I) the basis for the determination of the Secretary that the entity is not in compliance with the agreement, and (II) the actions that the entity should take to come into compliance with the agreement, and*

(*iii*) *provide the entity with a reasonable opportunity for a hearing, before an officer or employee of the Department of Health, Education, and Welfare designated for such purpose, on the matter specified in the notice.*

The Secretary may not terminate such an agreement before consulting with the National Council on Health Planning and Development respecting the proposed termination. Before the Secretary may permit the term of an agreement to expire without renewing the agreement, the Secretary shall make the consultations prescribed by clause (i) and the preceding sentence, give the entity with which the agreement was made notice of the intention not to renew the agreement and the reasons for not renewing the agreement, and provide, as prescribed by clause (iii), the entity an opportunity for a hearing on the matter specified in the notice.

(2) The Secretary may not enter into an agreement with any entity under paragraph (1) for designation as a health systems agency for a health service area unless the entity has submitted an application to the Secretary for designation as a health systems agency, and the Governor of each State in which the area is located has been consulted respecting such designation of such entity. Such an application shall contain assurances satisfactory to the Secretary that the applicant meets the requirements of section 1512(b) and is qualified to perform or is performing the functions prescribed by section 1513. In considering such applications, the Secretary shall give priority to [an] *any* application which has been recommended [for approval by (A) each entity which has developed a plan referred to in section 314(b) for all or part of the health service area with respect to which the application was submitted, and (B) each reigonal medical program established in such area under title IX] *by a Governor for approval.*

(3) An agreement under this subsection for the designation of a health systems agency may be renewed by the Secretary for a period not to exceed [twelve] *thirty-six* months if upon review (as provided in section 1535) of the agency's operation and performance of its functions, he determines that it has fulfilled, in a satisfactory manner, the functions of a health systems agency prescribed by section 1513 and continues to meet the requirements of section 1512(b) *If the Secretary determines thta a health systems agency has not met such requirements, the Secretary may impose in the renewal of the designation agreement of the agency such conditions as the Secretary determines are necessary to assure that the agency will meet such requirements before the expiration of the period for which the agreement is renewed. The Secretary may not impose on a health systems agency any such conditions unless the Secretary has—*

"(A) provided the agency with notice of his intent to impose such conditions and included in that notice specification of the requirements which the Secretary has determined the agency has not met and the basis for the determination of the Secretary that the imposition of such conditions is necessary to assure compliance with such requriements; and

"(B) provided the agency with a reasonable opportunity for a hearing, before an officer or employee of the Department of Health, Education, and Welfare designated for such purpose, on the conditions.

(4) Before renewing an agreement with a health systems agency under this subsection, the Secretary shall provide the State health planning and development agency of the State in which the health systems agency is located an opportunity to comment on the perform-

ance of such agency and to provide a recommendation on whether such agreement should be renewed and whether its renewal should be made subject to conditions as authorized by paragraph (3).

(5) If the Secretary enters into an agreement under this subsection with an entity or renews such as agreement, the Secretary shall notify the Governor of the State in which such entity is located of the agreement, its renewal, and, if any conditions have been imposed under paragraph (3), such conditions.

(d) If a designation *agreement* under subsection (b) or (c) of a health systems agency for a health service area is termiated before the date prescribed for its expiration *or is not renewed*, the Secretary shall, upon application and in accordance with subsection (b) or (c) (as the Secretary determines appropriate), enter into designation agreement with another entity to be the health systems agency for such area.

PLANNING GRANTS

SEC. 1516. (a) The Secretary shall make in each fiscal year a grant to each health systems agency with which there is in effect a designation agreement under subsection (b) or (c) of section 1515. A grant under this subsection shall be made on such conditions (*including submission of the health systems agency's budget*) as the Secretary determines is appropriate, shall be used by a health systems for compensation of agency personnel, collection of data, planning, and the performance of the functions of the agency[, and shall be available for obligation for a period not to exceed the period for which its designation agreement is entered into or renewed (as the case may be), except that in the case of a grant made to a conditionally designated entity with which the Secretary will not enter into a designation agreement under section 1515(c), such grant shall be available for obligation for such additional period as the Secretary determines such entity will require to satisfactorily terminate its activities under the agreement for its conditional designation]. *Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, except that (1) no funds under any grant to any agency may be obligated in any period in which a designation agreement is not in effect for such agency, and (2) notwithstanding clause (1), a grant made to a conditionally designated entity with which the Secretary will not enter into a designation agreement under section 1515(c) shall be available for obligation for such additional period as the Secretary determines such entity will require to satisfactorily terminate its activities under the agreement for its conditional designation.* A health systems agency may use funds under a grant under this subsection to make payments under contracts with other entities to assist the health systems agency in the performance of its functions; but it shall not use funds under such a grant to make payments under a grant or contract with another entity for the development or delivery of health services or resources.

[(b)(1) The amount of any grant under subsection (a) to a health systems agency designated under section 1515(b) shall be determined by the Secretary. The amount of any grant under subsection (a) to

any health systems agency designated under section 1515(c) shall be the lesser of—

[(A) the product of $0.50 and the population of the health service area for which the agency is designated, or

[(B) $3,750,000,

unless the agency would receive a greater amount under paragraph (2) or (3).

[(2)(A) If the application of a health systems agency for such a grant contains assurances satisfactory to the Secretary that the agency will expend or obligate in the period in which such grant will be available for obligation non-Federal funds meeting the requirements of subparagraph (B) for the purposes for which such grant may be made, the amount of such grant shall be the sum of—

[(i) the amount determined under paragraph (1), and

[(ii) the lesser of (I) the amount of such non-Federal funds with respect to which the assurances were made, or (II) the product of $0.25 and the population of the health service area for which the agency is designated.

[(B) The non-Federal funds which an agency may use for the pose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by subparagraph (A) shall—

[(i) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources, and

[(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

[(3) The amount of grant under subsection (a) to a health systems agency designated under section 1515(c) may not be less than $175,000.]

(b) The amount of any grant under subsection (a) to a health systems agency designated under section 1515(b) shall be determined by the Secretary.

(c)(1) Except as provided in paragraph (2), the amount of a grant under subsection (a) to a health system agency designated under section 1515(c) shall be the greater of the amount determined under subparagraph (A), (B), or (C) as follows:

(A) The amount of a grant to a health systems agency shall be the lesser of—

(i) if the population of the health service area for which the agency is designated—

(I) is not over one million, the product of $0.70 and the population of such area,

(II) is over one million but not over two million, the sum of $700,000 and the product of $0.50 and the population of such area which is over one million, or

(III) is over two million, the sum of $1,200,000 and the product of $0.30 and the population of such area which is over two million, or

(ii) $3,750,000.

(B)(i) If the application of the health systems agency for such grant states that the agency, in its latest fiscal year ending before the period in which such grant will be available for obligation, collected non-Federal funds meeting the requirements of clause (ii) for the purposes for which such grant may be made, the amount of such grant shall be the sum of—

(I) the amount determined under subparagraph (A) or (C), whichever is applicable, and

(II) the lesser of the amount of such non-Federal funds or the product of $0.25 and the population of the health service area for which the agency is designated.

(ii) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by clause (i) shall be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

(C) The amount of a grant to a health systems agency may not be less than—

(i) in the case of a grant made in the fiscal year ending September 30, 1979, $175,000 and, to the extent appropriations are specifically made after the date of the enactment of the Health Planning and Resources Development Amendments of 1979 to provide the additional amount authorized by this clause, an amount which bears the same ratio to $25,000 as the number of days beginning in the period beginning on such date of enactment and ending on the date of the period for which the grant was made bears to 365,

(ii) $200,000 in the case of a grant made in the fiscal year ending September 30, 1980,

(iii) $215,000 in the case of a grant made in the fiscal year ending September 30, 1981, and

(iv) $230,000 in the case of a grant made in any succeeding fiscal year.

(2) If the Secretary determines, after review of the budget of a health systems agency and after consultation with the State health planning and development agency of the State in which such agency is located, that the amount of a grant which is to be made to the agency in accordance with paragraph (1) is in excess of the amount needed by the agency to adequately perform its functions under its designation agreement, the amount of the grant to the agency shall be such amount as the Secretary determines the agency needs for the performance of such functions.

(3) If the Secretary determines, after review of the budget of a health systems agency, that the amount of a grant which is to be made to the agency in accordance with paragraph (1) is in excess of the amount needed by the agency to adequately perform its functions under its designation agreement, the amount of the grant to the agency shall be such amount as the Secretary determines the agency needs for the performance of such functions.

[(c)] *(d)* (1) For the purpose of making payments pursuant to grants made under subsection (a), there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1975, $90,000,000 for the fiscal year ending June 30, 1976, [and] $125,000,000 each for the fiscal years ending September 30, 1977, and September 30, 1978, *$150,000,000 for the fiscal year ending September 30, 1980, $160,000,000 for the fiscal year ending September 30, 1981, and $170,000,000 for the fiscal year ending September 30, 1982.*

[(2) Notwithstanding subsection (b), if the total of the grants to be made under this section to health systems agencies for any fiscal year exceeds the total of the amounts appropriated under paragraph (1) for that fiscal year, the amount of the grant for that fiscal year to each health systems agency shall be an amount which bears the same ratio to the amount determined for that agency for that fiscal year under subsection (b) as the total of the amounts appropriated under paragraph (1) for that fiscal year bears to the total amount required to make grants to all health systems agencies in accordance with the applicable provision of subsection (b); except that the amount of any grant to a health systems agency for any fiscal year shall not be less than $175,000, unless the amount appropriated for that fiscal year under paragraph (1) is less than the amount required to make such a grant to each health systems agency.]

(2) Of the amount appropriated under paragraph (1) for any fiscal year, the Secretary may use not more than 5 per centum of such amount to increase the amount of a grant in such fiscal year to a health systems agency under subsection (a) to assist the agency in meeting extraordinary expenses (including extraordinary expenses resulting from the agency's health systems area being located in more than one State or from the agency serving a large health service area) which would not be covered under the amount of the grant that would be available to the agency under subsection (c).

(3) Notwithstanding subsection (c)(1), if the total of the amounts appropriated under paragraph (1) for any fiscal year (reduced by the amount to be retained by the Secretary for use under paragraph (2)) is less than the amount required to make grants to each health system agency designated under section 1515(c) in the amount prescribed for such agency by subparagraph (A), (B), or (C) of such subsection, the Secretary shall make a pro rata reduction in the amount of the grant to each such agency, but, to the extent of available appropriations, no such agency shall receive a grant in an amount less than the amount prescribed by such subparagraph (C) for such fiscal year.

Part C—State Health Planning and Development

Designation of State health planning and development agencies

Sec. 1521. (a) For the purpose of the performance within each State of the health planning and development functions prescribed by section 1523, the Secretary shall enter into and renew agreements (described in subsection (b)) for the designation of a State health planning and development agency for each State.

(b)(1) A designation agreement under subsection (a) is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this [part] *title* referred to as the "State Agency") to administer the State administrative program prescribed by section 1522 and to carry out the State's health planning and development functions prescribed by section 1523. The Secretary may not enter into such an agreement with the Governor of a State unless—

(A) there has been submitted by the State a State administrative program which has been approved by the Secretary,

(B) an application has been made to the Secretary for such an agreement and the application contains assurances satisfactory to the Secretary that the agency selected by the Governor for designation as the State Agency has the authority and resources to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 1523, and

(C) in the case of an agreement entered into under paragraph (3), there has been established for the State a Statewide Health Coordinating Council meeting the requirements of section 1524.

(2)(A) The agreement entered into with a Governor of a State under subsection (a) may provide for the designation of a State Agency on a conditional basis with a view to determining the capacity of the designated State Agency to administer the State administrative program of the State and to carry out the health planning and development functions prescribed by section 1523. The Secretary shall require as a condition to the entering into of such an agreement that the Governor submit on behalf of the agency to be designated a plan for the agency's orderly assumption and implementation of such functions.

(B) The period of an agreement described in subparagraph (A) may not exceed thirty-six months*; except that the Secretary may extend the period for such additional time as he finds appropriate if he finds that the designated State Agency is making a good faith effort to comply with the requirements of section 1523.* During such period the Secretary may require that the designated State Agency perform only such of the functions of a State Agency prescribed by section 1523 as he determines it is capable of performing. The number and type of such functions shall, during such period, be progressively increased as the designated State Agency becomes capable of added responsibility, so that by the end of such period the designated State Agency may be considered for designation under paragraph (3).

(C) Any agreement with a Governor of a State entered into under subparagraph (A) may be terminated by the Governor upon ninety days' notice to the Secretary or by the Secretary upon ninety days' notice to the Governor.

(3)(*A*) If, on the basis of an application for designation as a State Agency (and, in the case of an agency conditionally designated under paragraph (2), on the basis of its performance under an agreement with a Governor of a State entered into under such paragraph), the Secretary determines that the agency is capable of fulfilling, in a satisfactory manner, the responsibilities of a State Agency, he shall

enter into an agreement with the Governor of the State designating the agency as the State Agency for the State. No such agreement may be made unless an application therefor is submitted to, and approved by, the Secretary. Any such agreement shall be for a term of not to exceed [twelve] *thirty-six* months, except that, prior to the expiration of such term, such agreement may be terminated—

[(A)] (*i*) by the Governor at such time and upon such notice to the Secretary as he may by regulation prescribe, or

[(B) by the Secretary, at such time and upon such notice to the Governor as the Secretary may by regulation prescribe, if the Secretary determines that the designated State Agency is not complying with or effectively carrying out the provisions of such agreement.]

(*ii*) *by the Secretary if the Secretary determines, in accordance with subparagraph (B), that the designated State Agency is not complying with the provisions of such agreement.*

An agreement under this paragraph shall contain such provisions as the Secretary may require to assure that the requirements of this part respecting State Agencies are complied with.

(*B*) *Before the Secretary may terminate an agreement with a designated State Agency under subparagraph (A)(ii), the Secretary shall—*

(*i*) *consult with the Statewide Health Coordinating Council of the State for which the State Agency is designated respecting the proposed termination,*

(*ii*) *give the State Agency notice of the intention to terminate the agreement and in the notice specify with particularity (I) the basis for the determination of the Secretary that the State Agency is not in compliance with the agreement, and (II) the actions that the State Agency should take to come into compliance with the agreement, and*

(*iii*) *provide the State Agency with a reasonable opportunity for a hearing, before an officer or employee of the Department of Health, Education, and Welfare designated for such purpose, on the matter specified in the notice.*

The Secretary may not terminate such an agreement before consulting with the National Council on Health Planning and Development respecting the proposed termination. Before the Secretary may permit the term of an agreement to expire without renewing the agreement, the Secretary shall make the consultations prescribed by clause (i) and the preceding sentence, give the entity with which the agreement was made notice of the intention not to renew the agreement and the reasons for not renewing the agreement, and provide, as prescribed by clause (iii), the entity an opportunity for a hearing on the matter specified in the notice.

(4) An agreement entered into under paragraph (3) for the designation of a State Agency may be renewed by the Secretary for a period not to exceed [twelve] *thirty-six* months if he determines that it has fulfilled, in a satisfactory manner, the responsibilities of a State Agency during the period of the agreement to be renewed and if the applicable State administrative program continues to meet the requirements of section 1522. *Before renewing an agreement under this paragraph with a State Agency for a State, the Secretary shall provide*

each health systems agency designated for a health service area located (in whole or in part) in such State an opportunity to comment on the performance of the State Agency and to provide a recommendation on whether such agreement should be renewed.

(c) If a designation agreement with the Government of a State entered into under subsection (b)(2) or (b)(3) is terminated before the date prescribed for its expiration, the Secretary shall, upon application and in accordance with subsection (b)(2). or (b)(3) (as the Secretary determines appropriate), enter into another agreement with the Governor for the designation of a State Agency.

[(d) If, upon the expiration of the fourth fiscal year which begins after the calendar year in which the National Health Planning and Resources Development Act of 1974 is enacted, an agreement under this section for the designation of a State Agency for a State is not in effect, the Secretary may not make any allotment, grant, loan, or loan guarantee, or enter into any contract, under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for the development, expansion, or support of health resources in such State until such time as such an agreement is in effect.]

(d) If an agreement under subsection (b)(3) for the designation of a State Agency for a State is not in effect upon the expiration of—

(1) the fourth fiscal year which begins after the calendar year in which the National Health Planning and Development Act of 1974 is enacted.

(2) the first regular session of the legislature of such State which begins after the promulgation of the regulations under section 117(e) of the Health Planning and Resources Development Amendments of 1979, or

(3) the sixth month after the month in which such regulations are promulgated,

whichever occurs later, no grant may be made to or contract entered into with the State under this Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, or the Drug Abuse Office and Treatment Act of 1972 until such time as such an agreement is in effect.

STATE ADMINISTRATIVE PROGRAM

SEC. 1522. (a) A State administrative program (hereinafter in this section referred to as the "State Program") is a program for the performance within the State by its State Agency of the functions Prescribed by section 1523. The Secretary may not approve a State program for a State unless it—

(1) meets the requirements of subsection (b);

(2) has been submitted to the Secretary by the Governor of the State at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary; and

(3) has been submitted to the Secretary only after the Governor of the State has afforded to the general public of the State a reasonable opportunity for a presentation of views on the State Program.

(b) The State Program of a State must—

(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 1523 and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

(2) contain or be supported by satisfactory evidence that the State Agency has under State law the authority to carry out such functions and the State Program in accordance with this part and contain a current budget for the operation of the State Agency;

(3) provide for adequate consultation with, and authority for, the Statewide Health Coordinating Council (prescribed by section 1524), in carrying out such functions and the State Program;

(4) (A) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibilities in the performance of such functions and the State Program, and require the State Agency to have a professional staff for planning and a professional staff for development, which staffs shall be of such size and meet such qualifications as the Secretary may prescribe;

(B) provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of such functions and the State Program, including methods relating to the establishment and maintenance of personnel standards on a merit basis consistent with such standards as are or may be established by the Civil Service Commission under section 208(a) of the Intergovernmental Personnel Act of 1970 (Public Law 91–648), but the Secretary shall exercise no authority with respect to the selection, tenure or office, and compensation of any individual employed in accordance with the methods relating to personnel standards on a merit basis established and maintained in conformity with this paragraph;

(5) require the State Agency to perform its functions in accordance with procedures and criteria established and published by it, which procedures and criteria shall conform to the requirements of section 1532;

(6) require the State Agency, *in accordance with applicable State law*, to (A) [conduct its business meetings] *hold in public meetings to conduct the business of the State Agency* in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available, upon request, to the public;

(7) (A) provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 306(e) of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care *and for the coordination by the State Agency in the conduct of its activities with any entity of the State which reviews the rates or budgets of health care facilities in the State*, and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency;

(8) provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and of their economic effectiveness;

(9) provide that the State Agency will from time to time, and in any event not less often than annually, review the State Program and submit to the Secretary required modifications;

(10) require the State Agency to (*A*) *assemble and report to the Secretary data (other than data which is regularly collected by any entity of the Department of Health, Education, and Welfare under a provision of law other than this title) which the Secretary may require to carry out his responsibilities under section 1501(e), including data on the personnel, facilities, and other resources needed to meet the goals set forth in the State health plan, and* (*B*) make such reports, in such form and containing such information, concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports;

(11) require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement of, and accounting for, amounts received from the Secretary under this title;

(12) permit the Secretary and the Comptroller General of the United States, or their representatives, to have access for the purpose of audit and examination to any books, documents, papers, and records of the State Agency pertinent to the disposition of amounts received from the Secretary under this title; and

(13) provide that if the State Agency makes a decision in the performance of a function under paragraph (3), (4), (5), or (6) of section 1523(a) or under title XVI which is inconsistent with a recommendation made under subsection (f)[, (g), or (h)] *or* (*g*) of section 1513 by a health systems agency within the State—

(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, *by any agency of the State authorized by such mechanism to make such review or, if there is no such State law,* by an agency of the State (other than the State health planning and development agency) designated by the Governor, and

(B) the decision of the reviewing agency *under subparagraph* (*A*) shall for purposes of this title and title XVI be considered the decision of the State health planning and development agency.

(c) The Secretary shall approve any State Program and any modification thereof which complies with subsections (a) and (b). The Secretary shall review for compliance with the requirements of this part the specifications of and operations under each State Program approved by him. Such review shall be conducted not less often than once each year.

STATE HEALTH PLANNING AND DEVELOPMENT FUNCTIONS

SEC. 1523. (a) Each State Agency of a State designated under section 1521(b)(3) shall, except as authorized under subsection (b), perform within the State the following functions:

(1) (*A*) Conduct the health planning activities of the State and implement those parts of the State health plan (under section 1524(c)(2)) and the plans of the health systems agencies within the State which relate to the government of the State, *and* (*B*) *determine the statewide health needs of the State after providing reasonable opportunity for the submission of written recommendations respecting such needs by the State health authority, the State mental health authority, and other agencies of the State government, designated by the Governor for the purpose of making such recommendations, and after consulting with the Statewide Health Coordinating Council.*

(2) Prepare [and review and revise as necessary (but at least annually)], *review at least biennially, and revise as necessary* a preliminary State health plan which shall be made up of the HSP's of the health systems agencies within the State. *In carrying out its functions under this paragraph, the State Agency shall refer the HSP's to the State health authority, the State mental health authority, and other agencies of the State government (designated by the Governor to make the review prescribed by this sentence) to review the goals and related resource requirements of the HSP's and to make written recommendations to the State Agency respecting such goals and requirements.* Such preliminary plan may, as found necessary by the State Agency, contain such revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs *determined under paragraph (1)(B)*. Such preliminary plan shall be submitted to the Statewide Health Coordinating Council of the State for approval or disapproval and for use in developing the State health plan referred to in section 1524(c).

(3) Assist the Statewide Health Coordinating Council of the State in the [review of the State medical facilities plan required under section 1603, and in the] performance of its functions generally.

(4)(A) Serve as the designated planning agency of the State for the purposes of section 1122 of the Social Security Act if the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to [new institutional health services proposed to be offered or developed within the State] *the obligation of capital expenditures within the State and the offering within the State of new institutional health services and the acquisition of major medical equipment* and which is satisfactory to the Secretary. [Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State.] *A certificate of need program*

shall not be found satisfactory to the Secretary unless each determination of need within the State is made by the State Agency solely on the basis of its review conducted in accordance with the procedures and criteria it has adopted in accordance with this title and regulations promulgated under it. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 1513 (f).

(5) After consideration of recommendations submitted by health systems agencies under section [1413(f)] *1513(f)* respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

(6) Review on a periodic basis (but not less often than every five years) [all institutional health services being offered in the State] *all institutional and home health services which are offered in the State and which have been designated by the Secretary for appropriateness review under this paragraph* and, after consideration of recommendations submitted by health systems agencies under section 1513(g) respecting the appropriateness of such services, make public its findings.

(7) Prepare an inventory of the health care facilities (other than Federal health care facilities) located in the State and evaluate on an ongoing basis the physical condition of such facilities. Such inventory and evaluations shall be reported to the health systems agencies designated for health service areas located (in whole or in part) in the State for purposes of the functions of the agency under section 1513(b).

If in determining the statewide health needs under paragraph (1)(B) or in preparing or revising a preliminary State health plan under paragraph (2) the State Agency does not take an action proposed in a recommendation submitted under the applicable paragraph, the State Agency shall when publishing such needs or health plan make available to the public a written statement of its reasons for not taking action.

(b)(1) Any function described in subsection (a) may be performed by another agency of the State government upon request of the Governor under an agreement with the State Agency satisfactory to the Secretary.

(2) The requirement of paragraph (4)(B) of subsection (a) shall not apply to a State Agency of a State until the expiration of the first regular session of the legislature of such State which begins after the date of enactment of this title.

(3) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health systems agency has made its recommendation under section 1513(g) with respect to the appropriateness of the service.

(c) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), or (6) of subsection (a) which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

STATEWIDE HEALTH COORDINATING COUNCIL

SEC. 1524. (a) A State health planning and development agency designated under section 1521 shall be advised by a Statewide Health Coordinating Council (hereinafter in this section referred to as the "SHCC") which (1) is organized in the manner described by subsection (b), and (2) performs the functions listed in subsection (c).

(b)(1) A SHCC of a State shall be composed in the following manner:

(A)(i) A SHCC shall have no fewer than sixteen representatives (*or if the number of representatives on the SHCC to which health systems agencies are entitled under the second sentence of clause (iii) is less than sixteen, no fewer than the number to which they are entitled*) appointed by the Governor of the State from lists of [at least five] nominees submitted to the Governor by each of the health systems agencies designated for health service areas which fall, in whole or in part, within the State. *Each agency shall submit a number of nominees to the Governor which is at least twice the number of representatives on the SHCC to which the agency is entitled.*

(ii) Each such health systems agency shall be entitled to the same number of representatives on the SHCC, *except that the number of representatives on the SHCC to which a health systems agency designated for a health service area which is not entirely within the State shall be a number which is based on the relationship of the population of the portion of such health service area within the State to the population of the largest health service area located entirely within the State, except that each such agency shall be entitled to at least one representative on the SHCC.*

[(iii) Each such health systems agency shall be entitled to at least two representatives on the SHCC. Of the representatives of a health systems agency, not less than one-half shall be individuals SHCC as he deems appropriate; except that (i) the number of who are consumers of health care and who are not providers of health care.]

(*iii*) *Except as otherwise provided in clause (ii) and this clause, each such health systems agency shall be entitled to at least two representatives on the SHCC. If there are more than ten health systems agencies within a State, each health systems agency within such State shall be entitled to only one representative on the SHCC. Of the representatives of health systems agencies on the SHCC, not less than one-half shall be individuals who are consumers of health care and who are not providers of health care.*

(B) In addition to the appointments made under subparagraph (A), the Govenror of the State may appoint such persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC as he deems appropriate; except that (i) the number of persons appointed to the SHCC under this subparagraph may not exceed 40 per centum of the total membership of the SHCC, and (ii) a majority of the persons appointed by the Governor shall be consumers of health care who are not also providers of health care.

(C) Not less than [one-third] *one-half* of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 1531(3)). *Members of a SHCC who are providers of health care shall represent the classification of providers listed in section 1512(b)(3)(C)(ii) and of such members at least one shall be a person engaged in the administration of a hospital.*

(D) Where two or more hospitals or other health care facilities of the Veterans' Administration are located in a State, the SHCC shall, in addition to the appointed members, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated as a representative of such facilities.

[(2) The SHCC shall select from among its members a chairman.]

(2) The Governor may select, by and with the advice and consent of the State senate, or, in the case of a State with a unicameral legislature, of the State legislature, the chairman of the SHCC from among the members of the SHCC. If the Governor does not select the chairman, the SHCC shall select the chairman from among its members.

(3) The SHCC shall conduct all of its business meetings in public, and shall meet at least once in each calendar quarter of a year.

(c) A SHCC shall perform the following functions:

(1) [Review] *Establish a uniform format for HSP's and review and coordinate at least biennally the HSP and review and coordinate at least annually the AIP* of each health systems agency within the State and report to the Secretary, for purposes of his review under section 1535(c), its comments on such HSP and AIP.

(2)(A) Prepare [and review and revise as necessary (but at least annually)], *review at least biennially, and revise as necessary* a State health plan which shall be made up of the HSP's of the health systems agencies within the State. Such plan may, as found necessary by the SHCC, contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs *as determined by the State Agency of the State.* Each health systems agency which participates in the SHCC shall make available to the SHCC its HSP for each year for integration into the State health plan and shall, as required by the SHCC, revise its HSP to achieve appropriate coordination with the HSP's of the other agencies which participate in the SHCC or to deal more effectively with statewide health needs *as determined by the State Agency of the State.*

(B) In the preparation and revision of the State health plan, the SHCC shall review and consider the preliminary State health plan submitted by the State [agency] *Agency* under section 1523(a)(2), and shall conduct a public hearing on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. Not less than thirty days prior to any such hearing, the SHCC shall publish in at least two newspapers of general circulation in the State a notice of its consideration of the proposed plan, the time and place of the hearing, the place at which interested persons may consult the plan in advance of the hearings, and the place and period during which to

direct written comment to the SHCC on the plan. *If in preparing or revising the State health plan the SHCC does not take an action proposed in a recommendation submitted under section 1523(a)(1)(B), the SHCC shall when publishing such plan make available to the public a written statement of its reasons for not taking such action.*

(C) The State health plan or any revised State health plan approved by the SHCC shall be the State health plan for the State for purposes of this title unless, within 60 days from the date the plan was approved, the Governor of the State disapproves the plan. The State health plan for a State may be disapproved by the Governor of the State only if the Governor determines that the plan does not effectively meet the statewide health needs of the State as determined by the State Agency for the State. In disapproving a State health plan, a Governor shall make public a detailed statement of the basis for the determination that the plan does not meet such needs and shall specify the changes in the plan which the Governor determines are needed to meet such needs. Subparagraph (B) does not apply to the preparation of revisions of a State health plan disapproved by a Governor.

(D) In carrying out its functions with respect to the goals and resources requirements for mental health services of the State health plan, the SHCC may establish a procedure under which persons (acting as or as part of an advisory group or subcommittee appointed by the SHCC) knowledgeable about mental health services (including services for substance abuse) will have the opportunity to make recommendations to the SHCC respecting such services.

(E) The State health authority, the State mental health authority, and other agencies of the State government, designated by the Governor, shall carry out those parts of the State health plan which relate to the government of the State.

(3) Review annually the budget of each such health systems agency and report to the Secretary, for purposes of his review under section 1535(a), its comments on such budget.

(4) Review applications submitted by such health systems agencies for grants under sections 1516 and 1640 and report to the Secretary its comments on such applications.

(5) Advise the State Agency of the State generally on the performance of its functions.

(6) Review annually and [approve or disapprove] *recommend approval or disapproval of (A)* any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this Act, the Community Mental Health Centers Act, *section 409 of the Drug Abuse Office and Treatment Act of 1972*, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, *and (B) any application (and any revision of an application) submitted to the Secretary by a State for a grant or contract under any provision of law referred to in clause (A) for projects in more than one health service area of the State.* Notwithstanding any other provision of this Act or any other Act referred to

in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review required by such sentence. [If a SHCC disapproves such a State plan or application, the Secretary may not make Federal funds available under such State plan or application until he has made, upon request of the Governor of the State which submitted such plan or application or another agency of such State, a review of the SHCC decision.] *If a SHCC recommmends disapproval of such a plan or application, the Secretary, after making a finding that such plan or application is not in conformity with the State health plan, may not make Federal funds available under such State plan or application. If the Secretary makes such a finding, he shall notify the Governor of his finding and the reasons therefor and advise him that he has 30 days in which to submit a revised State plan or application that conforms with the State health plan.* [If after such review] *If after reviewing a recommendation of a SHCC to disapprove such State plan or application*, the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision.

(d) No member of any SHCC may, in the exercise of any function of the SHCC described in subsection (c)(6), vote on any matter before the SHCC respecting any individual or entity with which such member has any substantial ownership, employment, fiduciary, contractual, creditor, or consultative relationship. Each SHCC shall require each of its members who has or has had such a relationship with an individual or entity involved in any matter before the SHCC to make a written disclosure of such relationship before any action is taken by the SHCC with respect to such matter in the exercise of any function under subsection (c) and to make such relationship public in any meeting in which such action is to be taken.

GRANTS FOR STATE HEALTH PLANNING AND DEVELOPMENT

SEC. 1525. (a) The Secretary shall make grants to State health planning and development agencies designated under subsection (b)(2) or (b)(3) of section 1521 to assist them in meeting the costs of their operation. [Any grant made under this subsection to a State Agency shall be available for obligation only for a period not to exceed the period for which its designation agreement is entered into or renewed.] *Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to a State Agency may be obligated in any period in which a designation agreement is not in effect for such State Agency.* The amount of any grant made under this subsection shall be determined by the Secretary, except that no grant to a designated State Agency may exceed 75 per centum of its operation costs (as determined under regulations of the Secretary) during the period for which the grant is available for obligation.

(b) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe; except that the Secretary may not make a grant to a State Agency unless he receives satis-

factory assurances that the State Agency will expend in performing the functions prescribed by section 1523 during the fiscal year for which the grant is sought an amount of funds from non-Federal sources which is at least as great as the average amount of funds expended, in the three years immediately preceding the fiscal year for which such grant is sought, by the State, for which such State Agency has been designated, for the purposes for which funds under such grant may be used (excluding expenditures of a nonrecurring nature).

(c) For the purpose of making payments under grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $30,000,000 for the fiscal year ending June 30, 1976, [and] $35,000,000 each for the fiscal years ending September 30, 1977, and September 30, 1978, *$35,000,000 for the fiscal year ending September 30, 1980, $37,000,000 for the fiscal year ending September 30, 1981, and $39,000,000 for the fiscal year ending September 30, 1982.*

GRANTS FOR RATE REGULATION

SEC. 1526. (a) For the purpose of demonstrating the effectiveness of Sttae Agencies regulating rates for the provision of health care, the Secretary may make grants to a State Agency designated, under an agreement entered into under section 1521(b)(3), for a State which (in accordance with regulations prescribed by the Secretary) has indicated an intent to regulate [(not later than six months after the date of the enactment of this title)] rates for the provision of health care within the State *or to any other entity of the government of a State which has so indicated an intent to regulate such rates.* [Not more than six State Agencies may receive grants under this subsection.]

(b)(1) [A State Agency] *An entity* which receives a grant under subsection (a) shall—

(A) provide the Secretary satisfactory evidence that the [State Agency] *entity* has under State law the authority to carry out rate regulation functions in accordance with this section and provide the Secretary a current budget for the performance of such functions by it;

(B) set forth in such detail as the Secretary may prescribe the qualifications for personnel having responsibility in the performance of such functions, and shall have a professional staff for rate regulation, which staff shall be headed by a Director;

(C) provide for such methods of administration as found by the Secretary to be necessary for the proper and efficient administration of such functions;

(D) *if it is a State Agency*, perform its functions in accordance with procedures established and published by it, which procedures shall conform to the requirements of section 1532;

(E) *if it is a State Agency*, comply with the requirements prescribed by paragraphs (6) through (12) of section 1522(b) with respect to the functions prescribed by subsection (a);

(F) provide for the establishment of a procedure under which the [State Agency] *entity* will obtain the recommendation of the

appropriate health systems agency prior to conducting a review of the rates charged or proposed to be charged for services; and

(G) meet such other requirements as the Secretary may prescribe.

If an entity which is not a State Agency receives a grant under subsection (a), such entity shall coordinate its activities under the grant with the State Agency for the State in which such entity is located, share with the State Agency data obtained from such activities, and for purposes of such activities, develop with the State Agency criteria for the review of hospital services, equipment, and facilities which guidelines are not in conflict with criteria adopted by the State Agency.

(2) In prescribing requirements under paragraph (1) of this subsection, the Secretary shall consider the manner in which [a State Agency] *an entity* shall perform its functions under a grant under subsection (a), including whether the [State Agency] *entity* should—

(A) permit those engaged in the delivery of health services to retain savings accruing to them from effective management and cost control,

(B) create incentives at each point in the delivery of health services for utilization of the most economical modes of services feasible,

(C) document the need for and cost implications of each new service for which a determination of reimbursement rates is sought, and

(D) employ for each type or class of person engaged in the delivery of health services—

(i) a unit for determining the reimbursement rates, and

(ii) a base for determining rates of change in the reimbursement rates,

which unit and base are satisfactory to the Secretary.

(c) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe, except that [(1) such a grant shall be available for obligation only during the one-year period beginning on the date such grant was made, and (2)] no [State Agency] *entity* may receive more than three grants under subsection (a). *Funds under a grant which remain available for obligation at the end of the fiscal year in which the grant has been made shall remain available for obligation in the succeeding fiscal year, but no funds under any grant to a State Agency may be obligated in any period in which a designation agreement is not in effect for such State Agency.*

(d) Each [State Agency] *entity* which receives a grant under subsection (a) shall report to the Secretary (in such form and manner as he shall prescribe) on the effectiveness of the rate regulation program assisted by such grant. The Secretary shall report annually to the Congress on the effectiveness of the programs assisted by the grants authorized by subsection (a).

(e) There are authorized to be appropriated to make payments under grants under subsection (a), $4,000,000 for the fiscal year ending June 30, 1975, $5,000,000 for the fiscal year ending June 30, 1976, [and] $6,000,000 each for the fiscal years ending September 30, 1977,

and September 3, 1978, *$6,000,000 for the fiscal year ending September 30, 1980, $7,000,000 for the fiscal year ending September 30, 1981, and $8,000,000 for the fiscal year ending September 30, 1982.*

certificate of need program

Sec. 1527. (a) The certificate of need program required by section 1523(a)(4)(B) shall, in accordance with this section, provide for the following:

(1) Review and determination of need under such program for—

(A) major medical equipment and institutional health services, and

(B) capital expenditures,

shall be made before the time such equipment is acquired, such services are offered, substantial expenditures are undertaken in preparation for such offering, or capital expenditures are obligated.

(2) The acquisition and offering of only such equipment and services as may be found by the State Agency to be needed; and the obligation of only those capital expenditures found to be needed by the State Agency.

(3) An application for a certificate of need for an institutional health service, medical equipment, or capital expenditure shall specify the time the applicant will require to make such service or equipment available or to obligate such expenditure and a timetable for making such service or equipment available or obligating such expenditure. After the issuance of a certificate of need, the State Agency shall review the progress of the holder of the ecrtificate in meeting the timetable specified in the approved application for the certificate. If on the basis of such a review the State Agency determines that the holder of a certificate is not meeting such timetable and is not making a good faith effort to meet it, the State Agency may, after considering any recommendation made by the health systems agency which received a report from the State Agency on such review, withdraw the certificate.

(4) In issuing a certificate of need, the State shall specify in the certificate the maximum amount of capital expenditures which may be obligated under such certificate. The program shall, in accordance with regulations promulgated by the Secretary, prescribe the extent to which a project authorized by a certificate of need shall be subject to further review if the amount of capital expenditures obligated or expected to be obligated for the project exceed the maximum specified in the certificate of need.

(5) The program shall provide that each decision of the State Agency not to issue a certificate of need shall, upon request of the person who applied for such certificate, be reviewed under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies or, if there is no such State law, by an entity (other than the State Agency) designated by the Governor.

(6) The program shall provide that each decision of the State Agency to issue a certificate of need (A) shall not be inconsistent

with the State health plan in effect for such State under section 1524(c), and (B) shall be issued by the State Agency solely on the basis of the record established in administrative proceedings held with respect to the application for such certificate.

(7) The program may permit reviews of applications for certificates of need to be conducted in such a manner that (A) comparisons of applications for such certificates may be made, and (B) priorities for approval of such applications may be established.

(8)(A)(i) Section 1532(b)(2) does not apply to review by a State Agency of an application for a certificate of need. Except as provided in clauses (ii) and (iii), such a review shall be completed before the expiration of the ninety-day period beginning on the date the State Agency provides the notice required by section 1532(b)(1). If a letter of findings of noncompliance with the requirements of title VI of the Civil Rights Act of 1964 has been issued by the Secretary to an applicant for a certificate of need, the State Agency may defer providing the notice required by section 1532(b)(1) until—

"(I) the Secretary has issued to the applicant a letter of findings of compliance with such requirements, or

"(II) in the administrative process begun by the issuance by the Secretary of a notice of deferral of Federal financial assistance a final decision of compliance with such requirements has been made or upon judicial review of a decision made in such administrative process a final decision of compliance with such requirements has been made,

whichever occurs first. If after a review of an application for a certificate of need has begun a letter of findings of noncompliance with the requirements of such title VI is issued to the applicant by the Secretary, the State Agency may suspend review of the application during the period beginning on the date such letter is issued and ending on the date whichever of the actions referred to in subclause (I) or (II) occurs and any period during which such review is so suspended shall not be counted in determining if the review has been completed within the time period prescribed by this subparagraph.

(ii) A review under paragraph (7)(A) of two or more applications for certificates of need shall be completed before the expiration of the ninety-day period prescribed by clause (i) or, if State law prescribes a longer period for reviews under that paragraph, before the expiration of such longer period. If a request is made to the State Agency for a hearing under section 1532(b)(8) on an application, the review of the application shall be completed before the expiration of the ninety-day period prescribed by clause (i) or, if State law prescribes a longer period for reviews involving such a hearing, before the expiration of such longer period.

(iii) If an applicant and the State Agency agree to a period of review of the applicant's application which is longer than the period prescribed by clause (i) or (ii), the review of the application shall be completed not later than the expiration of such longer period.

(B) Notwithstanding the requirements of section 1523(a)(4) and this section respecting State Agency determination of need, if a State Agency fails to complete its review of an application for a certificate of need in the applicable time prescribed by subparagraph (A), the application shall be considered approved and the State Agency shall issue the certificate.

(b)(1) Under the program a certificate of need shall not be required for the offering of an institutional health service, the acquisition of major medical equipment, or the obligation of a capital expenditure by—

(A) a health maintenance organization or any other provider of health services which organization or other provider provides or otherwise makes available ambulatory and inpatient health services on a prepaid basis to individuals enrolled with the provider to receive such services on such basis if at least 75 per centum of the patients who receive the institutional health service or the health service provided with such equipment or through such expenditure are individuals who are so enrolled; or

(B) any other provider of health services if the provider has entered into agreements with one or more providers of health services described in subparagraph (A) under which agreements—

(i) the institutional health service or the health service provided with such equipment or through such expenditure will be made available to individuals enrolled with such providers to receive ambulatory and inpatient health services on a prepaid basis, and

(ii) at least 75 per centum of the annual revenues from such service, equipment, or expenditure will be provided by such providers under such agreements.

(2)(A)(i) Each provider of health services which is exempt under paragraph (1) from obtaining a certificate of need for the offering of an institutional health service, the acquisition of major medical equipment, or the obligation of a capital expenditure shall, at least thirty days before contractual arrangements are entered into to offer such service, acquire such equipment, or obligate such expenditure, provide the health systems agency designated for the health service area in which the such service will be offered, equipment used, or expenditure obligated and the State Agency for the State in which such activity will occur the notice described in clause (ii).

(ii) The notice required by clause (i) shall (I) describe the service which will be offered, the equipment which will be acquired, or the purposes for which the capital expenditure will be obligated, (II) in the case of a provider of health services who is exempt under subparagraph (A) of paragraph (1), the basis for the provider's determination that of the patients who will receive the institutional health service or the service to be provided with such equipment or through such expenditure at least 75 per centum will be enrollees of the providers, and (III) in the case of a provider of health services who is exempt under subparagraph (B) of paragraph (1), the terms of each agreement described in such subparagraph which the provider has entered into and the basis for the provider's determination that at least

75 per centum of the revenues from the service, equipment, or expenditure will be provided under such agreements.

(B) If a provider of health services makes the offering, acquisition, or obligation described in the notice submitted by the provider under subparagraph (A), then not later than fifteen months after the date of such offering, acquisition, or obligation and annually thereafter, such provider of health services shall report, with respect to each year beginning on and after such date, to the health systems agency and the State Agency which received the notice under subparagraph (A)—

(i) if the provider is exempt under paragraph (1)(A) from obtaining a certificate of need for such offering, acquisition, or expenditure, the percentage of the patients receiving in the year reported on the services resulting from such offering, acquisition, or expenditure who were enrolled with the provider to receive ambulatory and inpatient health services on a prepaid basis, or

(ii) if the provider is exempt under paragraph (1)(B) from obtaining a certificate of need for such offering, acquisition, or expenditure, the revenues received in the year reported on under the agreements described in such paragraph from the service offered, equipment acquired, or expenditure obligated.

(3) If on the basis of a report filed by a provider of health services under paragraph (2)(B) a State Agency determines—

(A) in the case of a report filed by a provider under clause (i) of such paragraph, that in the year reported on less than 75 per centum of the patients who received the services with respect to which the report was made were enrolled with the provider to receive ambulatory and inpatient health services on a prepaid basis, or

(B) in the case of a report filed by a provider under clause (ii) of such paragraph, that in the year reported on the percent of revenues received under agreements described in subparagraph (A) from the service, equipment, or expenditure with respect to which the report was filed was less than 75 per centum of the total revenues received in such period from such equipment, service, or expenditure,

the State Agency shall notify in writing the provider of such determination, and such provider shall not be permitted to use, after sixty days after the receipt of such notice, such service, equipment, or expenditure in the provision of health services to other than individuals enrolled with a provider of ambulatory and inpatient health services to receive health services on a prepaid basis.

(4) If under paragraph (3) a provider of health services is not permitted to use a service, equipment, or expenditure to provide services to other than individuals enrolled with a provider of ambulatory and inpatient health services to receive health services on a prepaid basis—

(A) the provider shall make such annual reports to the State Agency involved as it may require to assure that the requirement of paragraph (3) is being met; and

(B) the State Agency involved shall—

(i) notify the Secretary that the provider is prohibited from using such service, equipment, or expenditure to provide services to individuals who are entitled to insurance

benefits under title XVIII of the Social Security Act and for whom the provider would otherwise receive reimbursement under section 1815 of such Act for the provision of such services, and

(ii) notify the State agency responsible for administering the State plan approved under title XIX of such Act that the provider is prohibited from using such service, equipment, or expenditure to provide services to individuals who are entitled to medical assistance under such plan and for whom the provider would otherwise receive reimbursement under the provision of the plan required by section 1902 (a) (13) (D) such Act for the provision of such services.

(5) If on the basis of a report filed under paragraph (4) (A) the *State Agency determines that the provider of health services is with respect to the service, equipment, or expenditure reported on meeting the requirements of paragraph (1), the State Agency shall notify the provider of the determination, and the requirement of paragraph (3) shall not apply to the provider. Such provider shall with respect to such service, equipment, or expenditure make the reports required by paragraph (2) (B). The first such report shall be due not later than fifteen months after the date of the receipt of the notice under this paragraph and shall apply with respect to the year beginning on that date. The State Agency shall also notify the Secretary and the State Agency notified under paragraph (4) (B) of the determination made under this paragraph.*

(6) For purposes of this subsection, a provider provides ambulatory and inpatient health services on a prepaid basis to individuals enrolled with the provider to receive such services on such basis if the provider is compensated (except for copayments) for the provision of such services by a payment which is paid on a periodic basis without regard to the date the health services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually furnished.

(7) The certificate of need program may apply to a health maintenance organization only to the extent that it is not exempt under paragraph (1) (A) and then only to the acquisition of major medical equipment, the offering of institutional health services, and the obligation of capital expenditures.

(c) Notwithstanding section 1532 (c), when an application is made by an osteopathic or allopathic facility for a certificate of need to construct, expand, modernize, acquire major medical equipment, or add services, the need for that construction, expansion, modernization, acquisition of equipment, or addition of services shall be considered on the basis of the need for and the availability in the community of services and facilities for osteopathic and allopathic physicians and their patients. The State Agency shall consider the application in terms of its impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

(d) Notwithstanding section 1532 (c), an application for a certificate of need for a capital expenditure which is required—

(1) to eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations,

(2) to comply with State licensure standards, or

(3) to comply with accreditation standards compliance with which is required to receive reimbursements under title XVIII of the Social Security Act of payments under a State plan for medical assistance approved under title XIX of such Act,

shall be approved, but only to the extent that the capital expenditure is required to eliminate or prevent such hazards or to comply with such standards.

(e) (1) Under the program a certificate of need shall be required for the acquisition of major medical equipment which will not be owned by or located in a health care facility if—

(A) the notice required by paragraph (2) is not filed in accordance with that paragraph with respect to such acquisition, or

(B) the State Agency finds, within thirty days after the date it receives a notice in accordance with that paragraph (2) with respect to such acquisition, that the equipment will be used to provide services for inpatients of a hospital.

(2) Before any person enters into a contractual arrangement to acquire major medical equipment which will not be owned by or located in a health care facility, such person shall notify the State Agency of the State in which such equipment will be located of such person's intent to acquire such equipment. Such notice shall be made in writing and shall be made at least thirty days before contractual arrangements are entered into to acquire the equipment with respect to which the notice is given.

(f) In granting certificates of need under such a program, a State Agency shall take into account recommendations made by health systems agencies within the State under section 1513(f).

GRANTS TO STATES FOR REDUCTION OF EXCESS HOSPITAL CAPACITY

SEC. 1528. (a) For the purpose of demonstrating the effectiveness of various means for reducing excesses in resources and facilities of hospitals (referred to in this section as "excess hospital capacity"), the Secretary may make grants to State Agencies designated under section 1521(b)(3) to assist such Agencies in—

(1) identifying (by geographic region or by health service) excess hospital capacity,

(2) developing programs to inform the public of the costs associated with excess hospital capacity,

(3) developing programs to reduce excess hospital capacity in a manner which will produce the greatest savings in the cost of health care delivery,

(4) developing means to overcome barriers to the reduction of excess hospital capacity, and

(5) any other activity related to the reduction of excess hospital capacity.

(b) Grants under subsection (a) shall be made on such terms and conditions as the Secretary may prescribe. The Secretary shall report annually to the Congress on the activities assisted with grants under subsection (a).

(c) There are authorized to be appropriated to make payments under grants under subsection (a) $4,000,000 for the fiscal year ending Sep-

tember 30, 1980 $4,000,000 for the fiscal year ending September 30, 1981, and $4,000,000 for the fiscal year ending September 30, 1982.

Part D—General Provisions

definitions

Sec. 1531. [For purposes of this title] *Except as otherwise provided, for purposes of this title:*

(1) The term "State" includes the District of Columbia [and the Commonwealth of Puerto Rico.].

(2) The term "Governor" means the chief executive officer of a State or his designee.

(3) The term "provider of health care" means an individual—

(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, optometrist, [or] physician assistant, *or ancillary personnel employed under the supervision of a physician*) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, *rehabilitation facilities*, substance abuse treatment facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; [or]

[(B) who is an indirect provider of health care in that the individual—

[(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

[(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following:

[(I) Fees or other compensation for research into or instruction in the provision of health care.

[(II) Entities engaged in the provision of health care or in such research or instruction.

[(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care.

[(IV) Entities engaged in producing drugs or such other articles.

[(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

[(iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.]

(B) who holds a fiduciary position with, or has a fiduciary interest in, any entity described in clause (ii) or (iv) of subparagraph (C) other than an entity described in such clause which is also an entity described in section 501(c)(3) of the Internal Revenue Code of 1954 and which does not have as its primary purpose the delivery of health care, the conduct of research, the

conduct of instruction for health professionals, or the production of drugs or articles described in clause (iii) of subparagraph (C);

(C) who receives (either directly or through his spouse) more than one-third of his gross annual income from any one or combination of—

(i) fees or other compensation for research into or instruction in the provision of health care,

(ii) entities engaged in the provision of health care or in research or instruction in the provision of health care,

(iii) producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care, or

(iv) entities engaged in producing drugs or such other articles;

(D) who is the spouse of an individual described in subparagraph (A), (B), or (C); or

(E) who is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

(4) The term "health resources" includes health services, health professions personnel, and health facilities, except that such term does not include Christian Science sanitoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(5) The term "institutional health services" means the health services provided thorough health care facilities [and health maintenance organizations (as such facilities and organizations] *(as such facilities* are defined in regulations prescribed under section 1122 of the Social Security Act) *and rehabilitation facilities* and includes the entities through which such services are provided.

(6) For purposes of sections 1523 and 1527, the term "capital expenditure" means an expenditure—

(A) made by or on behalf of a health care facility (as such facilities are defined in regulations prescribed under section 1122 of the Social Security Act) and

(B) (i) which (I) under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or (II) is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and

(ii) which (I) exceeds the expendture minimum, (II) substantially changes the bed capacity of the facility with respect to which the expenditure is made, or (III) substantially changes the services of such facility.

Such term does not include an expenditure to obtain (either by purchase or under lease or comparable arrangement) an existing health care facility the services or bed capacity of which is not changed in being so obtained. For purposes of subparagraph (B) (ii) (I), the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure described in subparagraph (B) (i) is made shall be included in determining if such expenditure exceeds the expendi-

ture minimum. Donations of equipment or facilities to a health care facility which is acquired directly by such facility would be subject to review under section 1527 shall be considered capital expenditures for purposes of section 1523 and 1527, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of such sections if a transfer of the equipment or facilities at fair market value would be subject to review under section 1527.

(7) For purposes of sections 1523 and 1527, the term "major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clincial laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of section 1861(s) of such Act.

(8) For purposes of paragraphs (6) and (7), the term "expenditure minimum" means (A) $150,000 for the twelve-month period beginning with the month in which this paragraph is enacted, and (B) for each twelve-month period thereafter, $150,000 or, if different, the figure in effect for the preceding twelve-month period, adjusted to reflct the change in the preceding twelve-month period in the composite construction cost index maintained by the Department of Commerce.

(9) The term "rehabilitation facility" means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

PROCEDURES AND CRITERIA FOR REVIEWS OF PROPOSED HEALTH SYSTEM CHANGES

SEC. 1532. (a) In conducting reviews pursuant to subsections (e), (f), and (g) of section 1513 or in conducting any other reviews of proposed or existing health services, each health systems agency shall (except to the extent approved by the Secretary) follow procedure, and apply criteria, developed and published by the agency in accordance with regulations of the Secretary; [and] in performing its review functions under section 1523, a State Agency shall (except to the extent approved by the Secretary) follow procedures and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary; *and in performing its review functions a Statewide Health Coordinating Council shall (except to the extent approved by the Secretary) follow procedures and apply criteria developed and published by the Council in accordance with regulations of the Secretary.* Procedures and criteria for reviews by health systems agencies [and States Agencies], *State Agencies, and Statewide Health Coordinating Councils* may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed. *Health systems agencies, the State Agency, and, if appropriate, the Statewide Health Coordinating priate, the Statewide Health Coordinating Council within each*

State shall cooperate in the development of procedures and criteria under this subsection to the extent appropriate to the achievement of efficiency in their reviews and consistency in criteria for such reviews. The Secretary shall review at least annually regulations promulgated under this section and provide opportunity for the submission of comments by health systems agencies, State agencies, and Statewide Health Coordinating Councils on the need for the revision of such regulations. At least forty-five days before the initial publication of a regulation proposing a revision in a regulation of the Secretary under this section, the Secretary shall, with respect to such proposed revision, consult with and solicit the recommendations from health systems agencies, State Agencies, and Statewide Health Coordinating Councils.

(b) Each health systems [agency and State Agency] *agency, State Agency, and Statewide Health Coordinating Council* shall include in the procedures required by subsection (a) at least the following:

(1) Written notification to affected persons of the beginning of a review.

(2) Schedules for reviews which provide that no review shall, to the extent practicable, take longer than ninety days from the date the notification described in paragraph (1) is made or in the case of non-substantive reviews, provision for a shortened review period.

(3) (*A*) Provision for persons subject to a review to submit to the [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* (in such form and manner as the [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* shall prescribe and publish) such information as the [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* may require concerning the subject of such review. *Each health systems agency, State Agency, and Statewide Health Coordinating Council shall develop procedures to assure that requests for information in connection with a review under this title are limited to only that information which is necessary for the agency, State Agency, or Statewide Health Coordinating Council to perform the review.*

(*B*) *Each health systems agency, State Agency, and Statewide Health Coordinating Council shall develop procedures to enable any person submitting data to designate data which he believes should not be released to the public and to submit such data separately. If the agency, State Agency, and Statewide Health Coordinating Council proposes to release for inspection any data designated under this paragraph, the agency, State Agency, or Statewide Health Coordinating Council shall notify, in writing and by certified mail, the person who submitted the data of the intent to release the data. The agency, State Agency, or Statewide Health Coordinating Council may not release such data until the expiration of 30 days after the person submitting the data has received the notice required by this paragraph.*

(4) Submission of applications (subject to review by a health systems [agency or a State Agency] *agency, State Agency, or Statewide Health Coordinating Council*) made under this Act or other provisions of law for Federal financial assistance for health

services to the health systems [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* at such time and in such manner as it may require.

(5) Submission of periodic reports by providers of health services and other persons subject to [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* review respecting the development of proposals subject to review.

(6) Provision for written findings which state the basis for any final decision or recommendation made by the [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council.*

(7) Notification of providers of health services and other persons subject to [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* review of the status of the [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* review of the health services or proposals subject to review, findings made in the course of such review, and other appropriate information respecting such review.

(8) Provision for public hearings in the course of [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* review if requested by persons directly affected by the review; and provision for public hearings, for good cause shown, respecting [agency and State Agency] *agency, State Agency, and Statewide Health Coordinating Council* decisions.

(9) Preparation and publication of regular reports by the [agency and State Agency] *agency, State Agency, and Statewide Health Coordinating Council* of the reviews being conducted (including a statement concerning the status of each such review) and of the reviews completed by the [agency and State Agency] *agency, State Agency, and Statewide Health Coordinating Council* (including a general statement of the findings and decisions made in the course of such reviews) since the publication of the last such report.

(10) Access by the general public to all applications reviewed by the [agency and State Agency] *agency, State Agency, and Statewide Health Coordinating Council* and to all other written materials [pertinent] *essential* to any [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* review.

(11) In the case of construction projects, submission to the agency and State Agency by the entities proposing the projects of letters of intent in such details as may be necessary to inform the agency and State Agency of the scope and nature of the projects at the earliest possible opportunity in the course of planning of such construction projects.

(c) Criteria required by subsection (a) for health systems [agency and State Agency] *agency, State Agency, and Statewide Health Coordinating Council* review shall include consideration of at least the following:

(1) The relationship of the health services being reviewed to the applicable [HSP and AIP.] *HSP, AIP, and State health plan.*

(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of alternatives, less costly, or more effective methods of providing such services.

(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or proposed to be provided.

[(6) In the case of health services proposed to be provided, the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services and the availability of alternative uses of such resources for the provision of other health services.]

(6) In the case of health services proposed to be provided—

(A) the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services,

(B) the effect of the means proposed for the delivery of such services on the clinical needs of health professional training programs in the area in which such services are to be provided,

(C) if such services are to be available in a limited number of facilities, the extent to which the health professions schools in the area will have access to the services for training purposes,

(D) the availability of alternative uses of such resources for the provision of other health services, and

(E) the extent to which such proposed services will be accessible to all the residents of the area to be served by such services.

(7) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may by regulation prescribe.

(8) The special needs and circumstances of health maintenance organizations for which assistance may be provided under title XIII *and of other providers of ambulatory and inpatient health services to enrollees on a prepaid basis.*

(9) In the case of a construction project—

(A) the costs and methods of the proposed construction, and

(10) The special circumstances of health service institutions and the need for conserving energy.

(B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project.

(11) In accordance with section 1502(b), the factors which affect the effect of the market forces of supply and demand on the health services being reviewed.

(*12*) *In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed.*

The criteria established by any health systems [agency or State Agency] *agency, State Agency, or Statewide Health Coordinating Council* under paragraph (8) shall be consistent with the standards and procedures established by the Secretary under section 1306(c) of this Act.

TECHNICAL ASSISTANCE FOR HEALTH SYSTEMS AGENCIES AND STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

SEC. 1533. (a) The Secretary shall provide (directly or through grants or contracts, or both) to designated health systems agencies and State Agencies (1) assistance in developing their health plans and approaches to planning various types of health services, (2) technical materials, including methodologies, policies, and standards appropriate for use in health planning, and (3) other technical assistance as may be necessary in order that such agencies may properly perform their functions.

(b) The Secretary shall include in the materials provided under subsection (a) the following:

(1)(A) Specification of the minimum data needed to determine the health status of the residents of a health service area and the determinants of such status.

(B) Specification of the minimum data needed to determine the use of health resources and services within a health service area.

(C) Specification of the minimum data needed to describe the use of health resources and services within a health servvice area.

(2) Planning approaches, methodologies, policies, and standards which shall be consistent with the guidelines established by the Secretary under section 1501 for appropriate planning and development of health resources, and which shall cover the priorities listed in section 1502.

(3) Guidelines for the organization and operation of health systems agencies and State Agencies including guidelines for—

(A) the structure of a health systems agency, consistent with section 1512(b), and of a State Agency, consistent with section 1522;

(B) the conduct of the planning and development processes;

(C) the performance of health systems agency functions in accordance with section 1513; and

(D) the performance of State Agency functions in accordance with section 1523.

(c) In order to facilitate the exchange of information concerning health services, health resources, and health planning and resources development practice and methodology, the Secretary shall establish a national health planning information center to support the health planning and resources development programs of health systems agencies, State Agencies, and other entities concerned with health

planning and resources development; to provide access to current information or health planning and resources development; and to provide informaton for use in the analysis of issues and problems related to health planning and resources development.

(d) The Secretary shall establish the following within one year of the date of enactment of this title:

(1) A uniform system for calculating the aggregate cost of operation and the aggregate volume of services provided by health services institutions as defined by the Secretary in regulations. Such system shall provide for the calculation of the aggregate volume to be based on:

(A) The number of patient days;

(B) The number of patient admissions;

(C) The number of out-patient visits; and

(D) Other relevant factors as determined by the Secretary.

(2) A uniform system for cost accounting and calculating the volume of services provided by health services institutions. Such system shall:

(A) Include the establishment of specific cost centers and, where appropriate, subcost centers.

(B) Include the designation of an appropriate volume factor for each cost center.

(C) Provide for an apprpriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health services institutions), and different sizes of such types of institutions.

(3) A uniform system for calculating rates to be charged to health insurers and other health institutions payors by health service institutions. Such system shall:

(A) Be based on an all inclusive rate for various categories of patients (including, but not limited to individuals receiving medical, surgical, pediatric, obstetric, and psychiatric institutional health services).

(B) Provide that such rates reflect the true cost of providing services to each such category of patients. The system shall provide that revenues derived from patients in one category shall not be used to support the provision of services to patients in any other category.

(C) Provide for an appropriate application of such system in the different types of institutions (including hospitals, nursing homes, and other types of health service institutions) and different sizes of such types of institutions.

(D) Provide that differences in rates to various classes of purchasers (including health insurers, direct service payors, and other health institution payors) be based on justified and documented differences in the costs of operation of health service institutions made possible by the actions of such purchasers.

(4) A classification system for health services institutions. Such classification system shall quantitatively describe and group health services institutions of the various types. Factors included in such classification system shall include—

(A) the number of beds operated by an institution:

(B) the geographic location of an institution;

(C) the operation of a postgraduate physician training program by an institution; and

(D) the complexity of services provided by an institution.

(5) A uniform system for the reporting by health services institutions of—

(A) the aggregate cost of operation and the aggregate volume of services, as calculated in accordance with the system established by the Secretary under paragraph (1);

(B) the costs and volume of services at various cost centers, and subcost centers, as calculated in accordance with the system established by the Secretary under paragraph (2); and

(C) rates, by category of patient and class of purchaser, as calculated in accordance with the system established by the Secretary under paragraph (3).

Such system shall provide for an appropriate application of such system in the different types of institutions (including hospital nursing homes, and other types of health services institutions) and different sizes of such institutions.

CENTERS FOR HEALTH PLANNING

SEC. 1534. (a) For the purposes of assisting the Secretary in carrying out this title, providing such technical and consulting assistance as health systems agencies and State Agencies may from time to time require, conducting research, studies and analyses of health planning and resources development, and developing health planning approaches, methodologies, policies, and standards, the Secretary shall by grants or contracts, or both, assist public or private nonprofit entities in meeting the costs of planning and developing new centers, and operating existing and new centers, for multidisciplinary health planning development and assistance. To the extent practicable, the Secretary shall provide assistance under this section so that at least five such centers will be in operation by June 30, 1976.

(b)(1) No grant or contract may be made under this section for planning or developing a center unless the Secretary determines that when it is operational it will meet the requirements listed in paragraph (2) and no grant or contract may be made under this section for operation of a center unless the center meets such requirements.

(2) The requirements referred to in paragraph (1) are as follows:

(A) There shall be a full-time director of the center who possesses a demonstrated capacity for substantial accomplishment and leadership in the field of health planning and resources development, and there shall be such additional professional staff as may be appropriate.

(B) The staff of the center shall represent a diversity of relevant disciplines.

(C) Such additional requirements as the Secretary may be regulation prescribe.

(c) Centers assisted under this section (1) may enter into arrangements with health systems agencies and State Agencies for the provision of such services as may be appropriate and necessary in assisting

the agencies and State Agencies in performing their functions under section 1513 or 1523, respectively, and (2) shall use methods (satisfactory to the Secretary) to disseminate to such agencies and State Agencies such planning approaches, methodologies, policies and standards as they develop.

(d) For the purpose of making payments pursuant to grants and contracts under subsection (a) there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1975, $8,000,000 for the fiscal year ending June 30, 1976, [and] $10,000,000 each for the fiscal years ending September 30, 1977, and September 30, 1978, *$10,000,000 for the fiscal year ending September 30, 1980, $11,000,000 for the fiscal year ending September 30, 1981, and $12,000,000 for the fiscal year ending September 30, 1982.*

REVIEW BY THE SECRETARY

SEC. 1535. (a) The Secretary shall review and approve or disapprove the annual budget of each designated health systems agency and State Agency. In making such review and approval or disapproval the Secretary shall consider the comments of Statewide Health Coordinating Councils submitted under section 1524(c)(3). Information submitted to the Secretary by a health systems agency or a State Agency in connection with the Secretary's review under this subsection shall be made available by the Secretary, upon request, to the appropriate committees (and their subcommittees) of the Congress.

(b) The Secretary shall prescribe performance standards covering the structure, operation, and performance of the functions of each designated health systems agency and State Agency, and he shall establish a reportiing system based on the performance standards that allow for continuous review of the structures, operation, and performance of the functions of such agencies.

(c) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated health systems agency to determine—

(1) the adequacy of the HSP of the agency for meeting the needs of the residents of the area for a healthful environment and for accessible, acceptable and continuous quality healthy care at reasonable costs, and the effectiveness of the AIP in achieving the system described in the HSP;

(2) if the structure, operation, and performance of the functions of the agency meet the requirements of sections 1512(b) and 1513;

(3) the extent to which the agency's governing body (and executive committee if any) represents the residents of the health service area for which the agency is designated;

(4) the professional credentials and competence of the staff of the agency;

(5) the appropriateness of the data assembled pursuant to section 1513(b) (1) and the quality of the analyses of such data;

(6) the extent to which technical and financial assistance from the agency have been utilized in an effective manner to achieve goals and objectives of the HSP and the AIP; and

(7) the extent to which it may be demonstrated that—

(A) the health of the residents in the agency's health service area has been improved;

(B) the accessibility, acceptability, continuity, and quality of health care in such area has been improved; and

(C) increases in costs of the provision of health care have been restrained.

(d) The Secretary shall review in detail at least every three years the structure, operation, and performance of the functions of each designated State Agency to determine—

(1) the adequacy of the State health plan of the Statewide Health Coordinating Council prepared under section 1524(c)(2) in meeting the needs of the residents of the State for a healthful environment and for accessible, acceptable, and continuous quality health care at reasonable costs;

(2) if the structure, operation, and performance of the functions of the State Agency meet the requirements of sections 1522 and 1523;

(3) the extent to which the Statewide Health Coordinating Council has a membership meeting, and has performed in a manner consistent with, the requirements of section 1524;

(4) the professional credentials and competence of the staff of the State Agency;

(5) the extent to which financial assistance provided under title XVI by the State Agency has been used in an effective manner of achieve the State's health plan under section 1524(c)(2); and

(6) the extent to which it may be demonstrated that—

(A) the health of the residents of the State has been improved;

(B) the accessibility, acceptability, continuity, and quality of health care in the State has been improved; and

(C) increases in costs of the provision of health care have been restrained.

(e) The Secretary shall report to the Congress on the results of the reviews conducted pursuant to subsections (c)(7) and (d)(6) respecing improvements in health and health care and restraints on increases in health care costs.

SPECIAL PROVISIONS FOR CERTAIN STATES AND TERRITORIES

SEC. 1536. (a) Any State which—

(1) has no county or municipal public health institution or department, and

(2) has, prior to the date of enactment of this title, maintained a health planning system which substantially complies with the purposes of this title,

and *the Commonwealth of Puerto Rico*, the Virgin Islands, Guam, the Trust Territory of the Pacific Islands, the Northern Mariana Islands and American Samoa shall each be considered in accordance with subsection (b) to be a State for purposes of this title.

(b) In the case of an entity which under subsection (a) is to be considered a State for purposes of this title—

(1) no health service area shall be established within it,
(2) no health systems agency shall be designated for it,
(3) the State Agency designated for it under section 1521 may, in addition to the functions prescribed by section 1523, perform the functions prescribed by section 1513 and shall be eligible to receive grants authorized by sections 1516 and 1640, and
(4) the chief executive officer shall appoint the Statewide Health Coordinating Council prescribed by section 1524 in accordance with regulations of the Secretary.

TITLE XVI—HEALTH RESOURCES DEVELOPMENT

[PART A—PURPOSE, STATE PLAN, AND PROJECT APPROVAL

[PURPOSE

[SEC. 1601. It is the purpose of this title to provide assistance, through allotments under part B and loans and loan guarantees and interest subsidies under part C, for projects for—
[(1) modernization of medical facilities;
[(2) construction of new outpatient medical facilities;
[(3) construction of new inpatient medical facilities in areas which have experienced (as determined under regulations of the Secretary) recent rapid population growth; and
[(4) conversion of existing medical facilities for the provision of new health services,
and to provide assistance, through grants under part D, for construction and modernization projects designed to prevent or eliminate safety hazards in medical facilities or to avoid noncompliance by such facilities with licensure or accreditation standards.

[GENERAL REGULATIONS

[SEC. 1602. The Secretary shall by regulation—
[(1) prescribe the general manner in which the State Agency of each State shall determine for the State medical facilities plan under section 1603 the priority among projects within the State for which assistance is available under this title, based on the relative need of different areas within the State for such projects and giving special consideration—
[(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,
[(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,
[(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of areas determined by the Secretary to be rural or urban poverty areas,
[(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid

noncompliance with State or voluntary licensure or accreditation standards, and

[(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

[(2) prescribe for medical facilities projects assisted under this title general standards of construction, modernization, and equipment for medical facilities of different classes and in different types of location;

[(3) prescribe criteria for determining needs for medical facility beds and needs for medical facilities, and for developing plans for the distribution of such beds and facilities;

[(4) prescribe criteria for determining the extent to which existing medical facilities are in need of modernization;

[(5) require each State medical facilities plan under section 1603 to provide for adequate medical facilities for all persons residing in the State and adequate facilities to furnish needed health services for persons unable to pay therefor; and

[(6) prescribe the general manner in which each entity which receives financial assistance under this title or has received financial assistance under this title or title VI shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

An entity subject to the requirements prescribed pursuant to paragraph (6) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably support the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

[STATE MEDICAL FACILITIES PLAN

[SEC. 1603. (a) Before an application for assistance under this title (other than part D) for a medical facility project described in section 1601 may be approved, the State Agency of the State in which such project is located must have submitted to the Secretary and had approved by him a State medical facilities plan. To be approved by the Secretary a State medical facilities plan for a State must—

[(1) prescribe that the State Agency of the State shall administer or supervise the administration of the plan and contain evidence satisfactory to the Secretary that the State Agency has the authority to carry out the plan in conformity with this title;

[(2) prescribe that the Statewide Health Coordinating Council of the State shall advise and consult with the State Agency in carrying out the plan;

[(3) be approved by the Statewide Health Coordinating Council as consistent with the State health plan developed pursuant to section 1524(c)(2);

[(4) set forth, in accordance with criteria established in regulations prescribed under section 1602 and on the basis of a state-

wide inventory of existing medical facilities, a survey of need, and the plans of health systems agencies within the State—

[(A) the number and type of medical facility beds and medical facilities needed to provide adequate inpatient care to people residing in the State, and a plan for the distribution of such beds and facilities in health services areas throughout the State,

[(B) the number and type of outpatient and other medical facilities needed to provide adequate public health services and outpatient care to people residing in the State, and a plan for the distribution of such facilities in health service areas throughout the State, and

[(C) the extent to which existing medical facilities in the State are in need of modernization or conversion to new uses;

[(5) set forth a program for the State for assistance under this title for projects described in section 1601, which program shall indicate the type of assistance which should be made available to each project and shall conform to the assessment of need set forth pursuant to paragraph (4) and regulations promulgated under section 1602;

[(6) set forth (in accordance with regulations promulgated under section 1602) priorities for the provision of assistance under this title for projects in the program set forth pursuant to paragraph (5);

[(7) provide minimum requirements (to be fixed in the discretion of the State Agency) for the maintenance and operation of facilities which receive assistance under this title, and provide for enforcement of such requirements;

[(8) provide for affording to every applicant for assistance for a medical facilities project under this title an opportunity for a hearing before the State Agency; and

[(9) provide that the State Agency will from time to time, but not less often than annually, review the plan and submit to the Secretary any modifications thereof which it considers necessary.

[(b) The Secretary shall approve any State medical facilities plan and any modification thereof which complies with the provisions of subsection (a) if the State Agency, as determined under the review made under section 1535(d), is organized and operated in the manner prescribed by section 1522 and is carrying out its functions under section 1523 in a manner satisfactory to the Secretary. If any such plan or modification thereof shall have been disapproved by the Secretary for failure to comply with subsection (a), the Secretary shall, upon request of the State Agency, afford it an opportunity for hearing.

[APPROVAL OF PROJECTS

[SEC. 1604. (a) For each project described in section 1601 and included within a State's State medical facilities plan approved under section 1603 there shall be submitted to the Secretary, through the State's State Agency, an application. An application for a grant under section 1625 shall be submitted directly to the Secretary. Except as provided in section 1625, the applicant under such an application may be a State, a political subdivision of a State or any other public entity,

or a private nonprofit entity. If two or more entities join in a project, an application for such project may be filed by any of such entities or by all of them.

[(b) (1) Except as authorized under paragraph (2), an application for any project shall set forth—

[(A) in the case of a modernization project for a medical facility for continuation of existing health services, a finding by the State Agency of a continued need for such services, and, in the case of any other project for a medical facility, a finding by the State Agency of the need for the new health services to be provided through the medical facility upon completion of the project;

[(B) a description of the site of such project;

[(C) plans and specifications therefor which meet the requirements of the regulations prescribed under section 1602;

[(D) reasonable assurance that title to such site is or will be vested in one or more of the entities filing the application or in a public or other nonprofit entity which is to operate the facility on completion of the project;

[(E) reasonable assurance that adequate financial support will be available for the completion of the project and for its maintenance and operation when completed, and, for the purpose of determining if the requirements of this subparagraph are met, Federal assistance provided directly to a medical facility which is located in an area determined by the Secretary to be an urban or rural poverty area or through benefits provided individuals served at such facility shall be considered as financial support;

[(F) the type of assistance being sought under this title for the project;

[(G) except in the case of a project under section 1625, a certification by the State Agency of the Federal share for the project;

[(H) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act) and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

[(I) in the case of a project for the construction or modernization of an outpatient facility, reasonable assurance that the services of a general hospital will be available to patients at such facility who are in need of hospital care; and

[(J) reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Sec-

retary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

[(2)(A) The Secretary may waive—

[(i) the requirements of subparagraph (C) of paragraph (1) for compliance with modernization and equipment standards prescribed pursuant to section 1602(2), and

[(ii) the requirement of subparagraph (D) of paragraph (1) respecting title to a project site,

in the case of an application for a project described in subparagraph (B).

[(B) A project referred to in subparagraph (B) is a project—

[(i) for the modernization of an outpatient medical facility which will provide general purpose health services, which is not part of a hospital, and which will serve a medically underserved population as defined in section 1633 or as designated by a health systems agency, and

[(ii) for which the applicant seeks (i) not more than $20,000 from the allotments made under part B to the State in which it is located, or (II) a loan under part C the principal amount of which does not exceed $20,000.

[(c) The Secretary shall approve an application submitted under subsection (b) (other than an application for a grant under section 1625) if—

[(1) in the case of a project to be assisted from an allotment made under part B, there are sufficient funds in such allotment to pay the Federal share of the project; and

[(2) the Secretary finds that—

[(A) the application (i) is in conformity with the State medical facilities plan approved under section 1603, (ii) has been approved and recommended by the State Agency, (iii) is for a project which is entitled to priority over other projects within the State as determined in accordance with the approved State medical facilities plan, and (iv) contains the assurances required by subsection (b); and

[(B) the plans and specifications for the project meet the requirements of the regulations prescribed pursuant to section 1602.

[(d) No application (other than an application for a grant under section 1625) shall be disapproved until the Secretary has afforded the State Agency an opportunity for a hearing.

[(e) Amendment of any approved application shall be subject to approval in the same manner as an original application.

[(f) Each application shall be reviewed by health systems agencies in accordance with section 1513(e).

[PART B—ALLOTMENTS

[ALLOTMENTS

[SEC. 1610. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make from sums appropriated for such fiscal year under section 1613 allotments among the States on the basis of

the population, the financial need, and need for medical facilities projects described in section 1601 of the respective States. The population of the States shall be determined on the basis of the latest figures certified by the Secretary of Commerce.

[(b)(1) The allotment to any State (other than Guam, American Samoa, the Virgin Islands, or the Trust Territory of the Pacific Islands) for any fiscal year shall be not less than $1,000,000; and the allotment to Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands for any fiscal year shall be not less than $500,000 each.

[(2) Notwithstanding paragraph (1), if the amount appropriated under section 1613 for any fiscal year is less than the amount required to provide allotments in accordance with paragraph (1), the amount of the allotment to any State for such fiscal year shall be an amount which bears the same ratio to the amount prescribed for such State by paragraph (1) as the amount appropriated for such fiscal year bears to the amount of appropriations needed to make allotments to all the States in accordance with paragraph (1).

[(c) Any amount allotted to a State for a fiscal year under subsection (a) and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the amounts allotted to such State for such purposes for such next two fiscal years; except that any such amount which is unobligated at the end of the first of such next two years and which the Secretary determines will remain unobligated at the close of the second of such next two years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title. Any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

[PAYMENTS FROM ALLOTMENTS

[SEC. 1611. (a) If with respect to any medical facility project approved under section 1604 the State Agency certifies (upon the basis of inspection by it) to the Secretary that, in accordance with approved plans and specifications, work has been performed upon the project or purchases have been made for it and that payment from the applicable allotment of the State in which the project is located is due for the project, the Secretary shall, except as provided in subsection (b), make such payment to the State.

[(b) The Secretary is authorized to not make payments to a State pursuant to subsection (a) in the following circumstances:

[(1) If such State is not authorized by law to make payments for an approved medical facility project from the payment to be made by the Secretary pursuant to subsection (a), or if the State so requests, the Secretary shall make the payment from the State allotment directly to the applicant for such project.

[(2) If the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 1612, payment by the Secre-

tary may, after he has given the State Agency notice and opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing.

In no event may the total of payments made under subsection (a) with respect to any project exceed an amount equal to the Federal share of such project.

[(c) In case an amendment to an approved application is approved as provided in section 1604 or the estimated cost of a project is revised upward, any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

[(d) In any fiscal year—

[(1) not more than 20 per centum of the amount of a State's allotment available for obligation in that fiscal year may be obligated for projects in the State for construction of new facilities for the provision of inpatient health care to persons residing in areas of the State which have experienced recent rapid population growth; and

[(2) not less than 25 per centum of the amount of a State's allotment available for obligation in that fiscal year shall be obligated for projects for outpatient facilities which will serve medically underserved populations.

In the administration of this part, the Secretary shall seek to assure that in each fiscal year at least one half of the amount obligated for projects pursuant to paragraph (2) shall be obligated for projects which will serve rural medically underserved populations.

[WITHHOLDING OF PAYMENTS AND OTHER COMPLIANCE ACTIONS

[SEC. 1612. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to the State Agency concerned finds—

[(1) that the State Agency is not complying substantially with the provisions required by section 1603 to be included in its State medical facilities plan,

[(2) that any assurance required to be given in an application filed under section 1604 is not being or cannot be carried out, or

[(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 1604,

the Secretary shall take the action authorized by subsection (b) unless, in the case of compliance with assurances, the Secretary requires compliance by other means authorized by law.

[(b) (1) Upon a finding described in subsection (a) and after notice to the State Agency concerned the Secretary may—

[(A) withhold from all projects within the State with respect to which the finding was made further payments from the State's allotment under section 1610, or

[(B) withhold from the specific projects with respect to which the finding was made further payments from the applicable State allotment under section 1610.

[(2) Payments may be withheld, in whole or in part, under paragraph (1)—

[(A) until the basis for the finding upon which the withholding was made no longer exists, or

[(B) if corrective action to make such finding inapplicable cannot be made, until the State concerned repays or arranges for the repayment of Federal funds paid under this part for projects which because of the finding are not entitled to such funds.

[(c) The Secretary shall investigate and ascertain, on a periodic basis, with respect to each entity which is receiving financial assistance under this title or which has received financial assistance under title VI or this title, the extent of compliance by such entity with the assurances required to be made at the time such assistance was received. If the Secretary finds that such an entity has failed to comply with any such assurance, the Secretary shall take the action authorized by subsection (b) or take any other action authorized by law (including an action for specific performance brought by the Attorney General upon request of the Secretary) which will effect compliance by the entity with such assurances. An appropriate action to effectuate compliance with any such assurance may be brought by a person other than the Secretary only if a complaint has been filed by such person with the Secretary and the Secretary has dismissed such complaint or the Attorney General has not brought a civil action for compliance with such assurance within 6 months after the date on which the complaint was filed with the Secretary.

[AUTHORIZATION OF APPROPRIATIONS

[SEC. 1613. Except as provided in section 1625(d), there are authorized to be appropriated for allotments under section 1610 $125,000,000 for the fiscal year ending June 30, 1975, $130,000,000 for the fiscal year ending June 30, 1976, and $135,000,000 each for the fiscal years ending September 30, 1977, and September 30, 1978.]

PART [C] *A*—LOANS AND LOAN GUARANTEES

AUTHORITY FOR LOANS AND LOAN GUARANTEES

[SEC. 1620. (a) The Secretary, during the period beginning July 1 1974, and ending September 30, 1978, may, in accordance with this part, make loans from the fund established under section 1622(d) to pay the Federal share of projects approved under section 1604.

[(b)(1) The Secretary, during the period beginning July 1, 1974, and ending September 30, 1978, may, in accordance with this part, guarantee to—

[(i) non-Federal lenders for their loans to nonprofit private entities for medical facilities projects, and

[(ii) the Federal Financing Bank for its loans to nonprofit private entities for such projects,

payment of principal and interest on such loans if applications for assistance for such projects under this title have been approved under section 1604.

[(2) In the case of a guarantee of any loan to a nonprofit private entity under this title, the Secretary shall pay, to the holder of such

loan and for and on behalf of the project for which the loan was made amounts sufficient to reduce by 3 per centum per annum the net effective interest rate otherwise payable on such loan. Each holder of such a loan which is guaranteed under this title shall have a contractual right to receive from the United States interest payments required by the preceding sentence.]

Sec. 1601. (a) (1) The Secretary, during the period ending September 30, 1982, may, in accordance with this part, make loans from the fund established under section 1602(d) to any public or nonprofit private entity for projects for—

(A) modernization of medical facilities.

(B) construction of new outpatient medical facilities.

(C) construction of new hospitals in (i) areas which have experienced (as determined under regulations of the Secretary) recent rapid population growth, or (ii) areas where merger or closure of medical facilities has resulted in a reduction in the number of hospital beds available in such areas, and

(D) conversion of existing medical facilities to outpatient medical facilities or facilities for long-term care.

(2) (A) The Secretary, during the period ending September 30, 1982, may, in accordance with this part, guarantee to—

(i) non-Federal lenders for their loans to nonprofit private entities for medical facilities projects described in paragraph (1), and

(ii) the Federal Financing Bank for its loans to nonprofit private entities for such projects,

payment of principal and interest on such loans.

(B) In the case of a guarantee of any loan to a nonprofit private entity under subparagraph (A) (i), which is located in an urban or rural poverty area, the Secretary shall pay, to the holder of such loan and for and on behalf of the project for which the loan was made, amounts sufficient to reduce by 3 per centum per annum of the net effect interest rate otherwise payable on such loan. Each holder of such a loan which is guaranteed under such subparagraph shall have a contractual right to receive from the United States interest payments required by the preceding sentence.

(b) The principal amount of a loan directly made or guaranteed under subsection (a) for a medical facilities project, when added to any other assistance provided such project under part B, may not exceed 90 per centum of the cost of such project unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the principal amount, when added to other assistance under part B, may cover up to 100 per centum of such costs.

(c) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, may not exceed such limitations as may be specified in appropriation Acts.

(d) The Secretary, with the consent of the Secretary of Housing and Urban Development, shall obtain from the Department of Housing and Urban Development such assistance with respect to the administration of this part as will promote efficiency and economy thereof.

[ALLOCATION AMONG THE STATES

[SEC. 1621. (a) For each fiscal year, the total amount of principal of—

[(1) loans to nonprofit private entities which may be guaranteed, or

[(2) loans which may be directly made,

under this part shall be allotted by the Secretary among the States, in accordance with regulations, on the basis of the population, financial need, and need for medical facilities projects described in section 1601 of the respective States. The population of the States shall be determined on the basis of the latest figures certified by the Secretary of Commerce.

[(b) Any amount allotted so a State for a fiscal year under subsection (a) and remaining unobligated at the end of such year shall remain available to such State, for the purpose for which made, for the next two fiscal years (and for such years only), in addition to the amounts allotted to such State for such purposes for such next two fiscal years; except that any such amount which is unobligated at the end of the first of such next two years and which the Secretary determines will remain unobligated at the close of the second of such next two years may be reallotted by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this title. Any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.]

GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

SEC. [1622] *1602.* (a)(1) The Secretary may not approve a loan guarantee for a project under this part unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States, and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this part.

(2)(A) The United States shall be entitled to recover from the applicant for a loan guarantee under this part the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this part (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

(C) Any loan guarantee made by the Secretary under this part shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts or makes a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

(D) Guarantees of loans under this part shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this title will be achieved.

(b)(1) The Secretary may not approve a loan under this part unless—

(A) the Secretary is reasonably satisfied that the applicant under the project for which the loan would be made will be able to make payments of principal and interest thereon when due, and

(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(2) Any loan made under this part shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to loans guaranteed under this part, minus 3 per centum per annum *in the case of a loan made for a project located in an urban or rural poverty area*, and (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States.

(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made under this part, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(c)(1) The Secretary shall from time to time, but with due regard to the financial interest of the United States, sell loans made under this part either on the private market or to the Federal National Mortgage Association in accordance with section 302 of the Federal National Mortgage Association Charter Act or to the Federal Financing Bank.

(2) Any loan so sold shall be sold for an amount which is equal (or approximately equal) to the amount of the unpaid principal of such loans as of time of sale.

(3)(A) The Secretary is authorized to enter into an agreement with the purchaser of any loan sold under this part under which the Secretary agrees—

(i) to guarantee to such purchaser (and any successor in interest to such purchaser) payments of the principal and interest payable under such loan, and

(ii) to pay as an interest subsidy to such purchaser (and any successor in interest of such purchaser) amounts which, when added to the amount of interest payable on such loan, are equivalent to a reasonable rate of interest on such loan as determined by the Secretary after taking into account the range of prevailing interest rates in the private market on similar loans and the risks assumed by the United States.

(B) Any agreement under subparagraph (A)—

(i) may provide that the Secretary shall act as agent of any such purchaser, for the purpose of collecting from the entity to which such loan was made and paying over to such purchaser any payments of principal and interest payable by such entity under such loan;

(ii) may provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement;

(iii) shall provide that, in the event of any default by the entity to which such loan was made in payment of principal or interest due on such loan, the Secretary shall, upon notification to the purchaser (or to the successor in interest of such purchaser), have the option to close out such loan (and any obligations of the Secretary with respect thereto) by paying to the purchaser (or his successor in interest) the total amount of outstanding principal and interest due thereon at the time of such notification; and

(iv) shall provide that, in the event such loan is closed out as provided in clause (iii), or in the event of any other loss incurred by the Secretary by reason of the failure of such entity to make payments of principal or interest on such loan, the Secretary shall be subrogated to all rights of such purchaser for recovery of such loss from such entity.

(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the fund established under subsection (d).

(5) If any loan to a public entity under this part is sold and guaranteed by the Secretary under this subsection, interest paid on such loan after its sale and any interest subsidy paid, under paragraph (3)(A)(ii), by the Secretary with respect to such loan which is received by the purchaser of the loan (or the purchaser's successor in interest) shall be included in the gross income of the purchaser or successor for the purpose of chapter 1 of the Internal Revenue Code of 1954.

(d)(1) There is established in the Treasury a loan and loan guarantee fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts—

(A) to enable him to make loans under this part,

(B) to enable him to discharge his responsibilities under loan guarantees issued by him under this part,

(C) for payemnt of interest under section [1620(b)(2)] *1601(a)(2)(B)* on loans guaranteed under this part,

(D) for repurchase of loans under subsections (c)(3)(B), [and]

(E) for payment of interest on loans which are sold and guaranteed[.], *and*

(F) to enable the Secretary to take the action authorized by subsection (f).

There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. There shall also be deposited in the fund amounts received by the Secretary in connection with loans and loan guarantees under this part and other property or assets derived by him from his operations respecting such loans and loan guarantees, including any money derived from the sale of assets.

(2) It at any time the sums in the funds are insufficient to enable the Secretary—

(A) to make payments of interest under section [1620(b)(2).] *1601(a)(2)(B)*,

(B) to otherwise comply with guarantees under this part of loans to nonprofit private entities,

(C) in the case of a loan which was made, sold, and guaranteed under this part, to make the purchaser of such loan payments of principal and interest on such loan after default by the entity to which the loan was made, or

(D) to repurchase loans under subsection (c)(3)(B), [and]

(E) to make payments of interest on loans which are sold and guaranteed, *and*

(F) to enable the Secretary to take the action authorized by subsection (f),

he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

(e)(1) The assets, commitments, obligations, and outstanding balances of the loan guarantee and loan fund established in the Treasury by section 626 shall be transferred to the fund established by subsection (d) of this section.

(2) To provide additional capitalization for the fund established under subsection (d) there are authorized to be appropriated to the fund, such sums as may be necessary for the fiscal years ending June 30, 1975, June 30, 1976, September 30, 1977, and September 30, 1978.

(f) (1) The Secretary may take such action as may be necessary to prevent a default on a loan made or guaranteed under this part or under title VI, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes. Any such expenditure made under the preceding sentence on behalf of a medical facility shall be made under such terms and conditions as the Secretary shall prescribe, including the implementation of such organizational, operational, and financial reforms as the Secretary determines are appropriate and the disclosure of such financial or other information as the Secretary may require to determine the extent of the implementation of such reforms.

(2) The Secretary may take such action, consistent with State law, as he deems appropriate to protect the interest of the United States in the event of a default on a loan made or guaranteed under this part or under title VI, including for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.

PART [D] *B*—PROJECT GRANTS

PROJECT GRANTS

SEC. [1625.] *1610.* (a) *(1)* The Secretary may make grants for construction or modernization projects designed to [(1)] *(A)* eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or [(2)] *(B)* avoid noncompliance with State or voluntary licensure or accreditation standards. A grant under this [subsection] *paragraph* may only be made *to a nonprofit private entity or* to a State or political subdivision of a State, including any city, town, county, borough, hospital district authority, or public or quasi-public corporation, for a project described in the preceding sentence for any medical facility owned or operated by [it] *such entity, State, or political subdivision of a State.*

[(b) An application for a grant under subsection (a) may not be approved under section 1604 unless it contains assurances satisfactory to the Secretary that the applicant making the application would not be able to complete the project for which the application is submitted without the grant applied for.

[(c) The amount of any grant under subsection (a) may not exceed 75 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

[(d) Of the sums appropriated under section 1613 for a fiscal year, there shall be made available for grants under subsection (a) for such fiscal year 22 per centum of such sums. In addition to the amounts

made available for such grants under the preceding sentence to be appropriated $67,500,000 for such fiscal year for such grants.]

(2) The amount of any grant under paragraph (1) may not exceed 75 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

(3) There are authorized to be appropriated for grants under paragraph (1) $50,000,000 for the fiscal year ending September 30, 1980, $50,000,000 for the fiscal year ending September 30, 1981, and $50,000,000 for the fiscal year ending September 30, 1982.

(b) (1) The Secretary may make grants to public and nonprofit entities for projects for (A) construction or modernization of outpatient medical facilities which are located apart from hospitals and which will provide services for medically underserved populations, and (B) conversion of existing facilities into outpatient medical facilities or facilities for long-term care to provide services for such populations.

(2) The amount of any grant under paragraph (1) may not exceed 80 per centum of the cost of the project for which the grant is made unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the grant may cover up to 100 per centum of such costs.

(3) There are authorized to be appropriated for grants under paragraph (1) $15,000,000 for the fiscal year ending September 30, 1980, $15,000,000 for the fiscal year ending September 30, 1981, and $15,000,000 for the fiscal year ending September 30, 1982.

PART [E] *C*—GENERAL PROVISIONS

JUDICIAL REVIEW

[SEC. 1630. If—

[(1) the Secretary refuses to approve an application for a project submitted under section 1604, the State Agency through which such application was submitted, or

[(2) any State is dissatisfied with, or any entity will be adversely affected by, the Secretary's action under section 1612, such State or entity,

may appeal to the United States court of appeals for the circuit in which such State Agency, State, or entity is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence and the Secretary may thereupon make new or modified findings

of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the Court, operate as a stay of the Secretary's action.]

GENERAL REGULATIONS

SEC. 1620. The Secretary shall by regulation—

(1) prescribe the manner in which he shall determine the priority among projects for which assistance is available under part A or B, based on the relative need of different areas of such projects and giving special consideration—

(A) to projects for medical facilities serving areas with relatively small financial resources and for medical facilities serving rural communities,

(B) in the case of projects for modernization of medical facilities, to projects for facilities serving densely populated areas,

(C) in the case of projects for construction of outpatient medical facilities, to projects that will be located in, and provide services for residents of, areas determined by the Secretary to be rural or urban poverty areas,

(D) to projects designed to (i) eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or (ii) avoid noncompliance with State or voluntary licensure or accreditation standards, and

(E) to projects for medical facilities which, alone or in conjunction with other facilities, will provide comprehensive health care, including outpatient and preventive care as well as hospitalization;

(2) prescribe for medical facilities projects assisted under part A or B general standards of construction, modernization, and equipment, which standards may vary on the basis of the class of facilities and their location; and

(3) prescribe the general manner in which each entity which receives financial assistance under part A or B or has received financial assistance under part A or B or title VI shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

An entity subject to the requirements prescribed pursuant to paragraph (3) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably supports the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

APPLICATIONS

SEC. 1621. (a) No loan, loan guarantee, or grant may be made under part A or B for a medical facilities project unless an application for such project has been submitted to and approved by the Secretary. If two or more entities join in a project, an application for such project may be filed by any of such entities or by all of them.

(b) (1) An application for a medical facilities project shall be submitted in such form and manner as the Secretary shall by regulation prescribe and shall, except as provided in paragraph (2), set forth—

(A) in the case of a modernization project for a medical facility for continuation of existing health services, a finding by the State agency of a continued need for such services, and, in the case of any other project for a medical facility, a finding by the State Agency of the need for the new health services to be provided through the medical facility upon completion of the project;

(B) in the case of an application for a grant, assurances satisfactory to the Secretary that (i) the applicant making the application would not be able to complete the project for which the application is submitted without the grant applied for, and (ii) in the case of a project to construct a new medical facility, it would be inappropriate to convert an existing medical facility to provide the services to be provided through the new medical facility;

(C) a description of the site of such project;

(D) plans and specifications therefor which meet the requirements of the regulations prescribed under section 1620(2);

(E) reasonable assurance that title to such site is or will be vested in one or more of the entities filing the application or in a public or other nonprofit entity which is to operate the facility on completion of the project;

(F) reasonable assurance that adequate financial support will be available for the completion of the project and for its maintenance and operation when completed, and, for the purpose of determining if the requirements of this subparagraph are met, Federal assistance provided directly to a medical facility which is located in an area determined by the Secretary to be an urban or rural poverty area or through benefits provided individuals served at such facility shall be considered as financial support;

(G) the type of assistance being sought under part A or B for the project;

(H) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

(I) in the case of a project for the construction or modernization of an outpatient facility, reasonable assurance that the serv-

ices of a general hospital will be available to patients at such facility who are in need of hospital care; and

(J) reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

(2)(A) The Secretary may waive—

(i) the requirements of subparagraph (D) of paragraph (1) for compliance with modernization and equipment standards prescribed pursuant to section 1620(2), and

(ii) the requirement of subparagraph (E) of paragraph (1) respecting title to a project site,

in the case of an application for a project described in subparagraph (B) of this paragraph.

(B) A project referred to in subparagraph (A) is a project—

(i) for the modernization of an outpatient medical facility which will provide general purpose health services, which is not part of a hospital, and which will serve a medically underserved population as defined in section 1624 or as designated by a health systems agency, and

(ii) for which the applicant seeks a loan under part A the principal amount of which does not exceed $20,000.

RECOVERY

SEC. [1631.] *1622.* (a) If any facility constructed, modernized, or converted with funds provided under this title is, at any time within twenty years after the completion of such construction, modernization, or conversion with such funds—

(1) sold or transferred to any person or entity (A) which is not qualified to file an application under section [1604.] *1621*, or (B) which is not approved as a transferee by the State Agency of the State in which such facility is located, or its successor; or

(2) not used as a medical facility, and the Secretary has not determined that there is good cause for termination of such use,

the United States shall be entitled to recover from either the transferor or the transferee in the case of a sale or transfer or from the owner in case of termination of use an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of such facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction, modernization, or conversion of such project or projects. Such right of recovery shall not constitute a lien upon such facility prior to judgment.

(b) The Secretary may waive the recovery rights of the United States under subsection (a) with respect to a facility in any State—

(1) if (as determined under regulations prescribed by the Secretary) the amount which could be recovered under subsection (a) with respect to such facility is applied to the development, expansion, or support of another medical facility located in such State which has been approved by the Statewide Health Coordinating Council for such State as consistent with the State health plan established pursuant to section 1524(c); or

(2) if the Secretary determines, in accordance with regulations that there is good cause for waiving such requirement with respect to such facility.

If the amount which the United States is entitled to recover under subsection (a) exceeds 90 per centum of the total cost of the construction or modernization project for a facility, a waiver under this subsection shall only apply with respect to an amount which is not more than 90 per centum of such total cost.

[STATE] CONTROL OF OPERATIONS

SEC. [1632.] *1623.* Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this title.

DEFINITIONS

SEC. [1633.] *1624.* [For the purposes of this title] *Except as provided in section 1642(f), for purposes of this title*—

[(1)] The term "State" includes the Commonwealth of Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Virgin Islands, and the District of Columbia.

[(2) The term "Federal share" means the proportion of the cost of a medical facilities project which the State Agency determines the Federal Government will provide under allotment payments or a loan or loan guarantee under this title, except that—

[(A) in the case of a modernization project—

[(i) described in section 1604(b)(2)(B), and

[(ii) the application for which received a waiver under section 1604(b)(2)(A),

the proportion of the cost of such project to be paid by the Federal Government under allotment payments or a loan may not exceed $20,000 and may not exceed 100 per centum of the first $6,000 of the cost of such project and 66⅔ per centum of the next $21,000 of such cost,

[(B) in the case of a project (other than a project described in subparagraph (A)) to be assisted from an allotment made under part B, the proportion of the cost of such project to be paid by the Federal Government may not exceed 66⅔ unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the proportion of the cost of such project to be paid by the Federal Government may be 100 per centum, and

[(C) in the case of a project (other than a project described in subparagraph (A)) to be assisted with a loan or loan guarantee made under part C, the principal amount of the loan directly made or guaranteed for such project, when added to any other assistance provided the project under this title, may not exceed 90 per centum of the cost of such project unless the project is located in an area determined by the Secretary to be an urban or rural poverty area, in which case the principal amount, when added to other assistance under this title, may cover up to 100 per centum of the cost of the project.]

[(3)](*1*) The term "hospital" includes general, tuberculosis, and other types of hospitals, and related facilities, such as laboratories, outpatient departments, nurses' home facilities, extended care facilities, facilities related to programs for home health services, self-care units, and central service facilities, operated in connection with hospitals, and also includes education or training facilities for health professional personnel operated as an integral part of a hospital, but does not include any hospital furnishing primarily domiciliary care.

[(4)](*2*) The term "public health center" means a publicly owned facility for the provision of public health services, including related publicly owned facilities such as laboratories, clinics, and administrative offices operated in connection with such a facility.

[(5)](*3*) The term "nonprofit" as applied to any facility means a facility which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

[(6)](*4*) The term "outpatient medical facility" means a medical facility (located in or apart from a hospital) for the diagnosis or diagnosis and treatment of ambulatory patients (including ambulatory inpatients)—

(A) which is operated in connection with a hospital,

(B) in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State, or in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State; or

(C) which offers to patients not requiring hospitalization the services of licensed physicians in various medical specialties and which provides to its patients a reasonably full-range of diagnostic and treatment services.

[(7)](*5*) The term "rehabilitation facility" means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of—

(A) medical evaluation and services, and

(B) psychological, social, or vocational evaluation and services,

under competent professional supervision, and in the case of which the major portion of the required evaluation and services is furnished within the facility; and either the facility is operated

in connection with a hospital, or all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State.

[(8)] (*6*) The term "facility for long-term care" means a facility (including a skilled nursing or intermediate care facility) providing in-patient care for convalescent or chronic disease patients who required skilled nursing or intermediate care and related medical services—

(A) which is a hospital (other than a hospital primarily for the care and treatment of mentally ill or tuberculosis patients) or is operated in connection with a hospital, or

(B) in which such care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine or surgery in the State.

[(9)] (*7*) The term "construction" means construction of new buildings and initial equipment of such buildings and, in any case in which it will help to provide a service not previously provided in the community, equipment of any buildings; including architects' fees, but excluding the cost of off-site improvements and, except with respect to public health centers, the cost of the acquisition of land.

[(10)] (*8*) The term "cost" as applied to construction modernization, or conversion means the amount found by the Secretary to be necessary for construction, modernization, or conversion, respectively, under a project, except that, in the case of a modernization project or a project assisted under part D, such term does not include any amount found by the Secretary to be attributable to expansion of the bed capacity of any facility.

[(11)] (*9*) The term "modernization" includes the alteration, expansion, major repair (to the extent permitted by regulations), remodeling, replacement, and renovation of existing buildings (including initial equipment thereof), and the replacement of obsolete equipment of existing buildings.

[(12)] (*10*) The term "title," when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than twenty-five years' undisturbed use and possession for the purpose of construction, modernization, or conversion and operation of the project for a period of not less than (A) twenty years in the case of a project assisted under an allotment or grant under this title, or (B) the term of repayment of a loan made or guaranteed under this title in the case of a project assisted by a loan or loan guarantee.

[(13)] (*11*) The term "medical facility" means a hospital, public health center, outpatient medical facility, rehabilitation facility, facility for long-term care, or other facility (as may be designated by the Secretary) for the provision of health care to ambulatory patients.

[(14)] (*12*) The term "State Agency" means the State health planning and development agency of a State designated under title XV.

[(15)] *(13)* The term "urban or rural poverty area" means an urban or rural geographical area (as defined by the Secretary) in which a percentage (as defined by the Secretary in accordance with the next sentence) of the residents of the area have incomes below the poverty level (as defined by the Secretary of Commerce). The percentage referred to in the preceding sentence shall be defined so that the percentage of the population of the United States residing in urban and rural poverty areas is—

(A) not more than the percentage of the total population of the United States with incomes below the poverty level (as so defined) plus five per centum, and

(B) not less than such percentage minus five per centum.

[(16)] *(14)* The term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of health facilities or a population group designated by the Secretary as having a shortage of such facilities.

FINANCIAL STATEMENTS; RECORDS AND AUDIT

SEC. [1634.] *1625.* (a) In the case of any facility for which an allotment payment, grant, loan, or loan guarantee has been made under this title, the applicant for such payment, grant, loan, or loan guarantee (or, if appropriate, such other person as the Secretary may prescribe) shall file at least annually with the State Agency for the State in which the facility is located a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show—

(1) the financial operations of the facility, and

(2) the costs to the facility of providing health services in the facility and the charges made by the facility for providing such services,

during the period with respect to which the statement is filed.

(b)(1) Each entity receiving Federal assistance under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such entity of the proceeds of such assistance, the total cost of the project in connection with which such assistance is given or used, the amount of that portion of the cost of the project supplied by other sources, and such other records as will facilitate an effective audit.

(2) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of such entities which in the opinion of the Secretary or the Comptroller General may be related or pertinent to the assistance referred to in paragraph (1).

(c) Each such entity shall file at least annually with the Secretary a statement which shall be in such form, and contain such information, as the Secretary may require to accurately show—

(1) the financial operations of the facility constructed or modernized with such assistance, and

(2) the costs to such facility of providing health services in such facility, and the charges made for such services, during the period with respect to which the statement is filed.

TECHNICAL ASSISTANCE

SEC. [1635.] *1626.* The Secretary shall provide (either through the Department of Health, Education, and Welfare or by contract) all necessary technical and other nonfinancial assistance to any public or other nonprofit entity which is eligible to apply for assistance under this title to assist such entity in developing applications to be submitted to the Secretary under section [1604]. *1621.* The Secretary shall make every effort to inform eligible applicants of the availability of assistance under this title.

ENFORCEMENT OF ASSURANCES

SEC. 1627. The Secretary shall investigate and ascertain, on a periodic basis, with respect to each entity which is receiving financial assistance under this title or which has received financial assistance under title VI or this title, the extent of compliance by such entity with the assurances required to be made at the time such assistance was received. If the Secretary finds that such an entity has failed to comply with any such assurance, the Secretary shall report such noncompliance to the health systems agency for the health service area in which such entity is located and the State health planning and development agency of the State in which the entity is located and shall take any action authorized by law (including an action for specific performance brought by the Attorney General upon request of the Secretary) which will effect compliance by the entity with such assurances. An action to effectuate compliance with any such assurance may be brought by a person other than the Secretary only if a complaint has been filed by such person with the Secretary and the Secretary has dismissed such complaint or the Attorney General has not brought a civil action for compliance with such assurance within 6 mo nths after the date on which the complaint was filed with the Secretary.

PART [F] *D*—AREA HEALTH SERVICES DEVELOPMENT FUNDS

DEVELOPMENT GRANTS FOR AREA HEALTH SERVICES DEVELOPMENT FUNDS

SEC. 1640. (a) The Secretary shall make in each fiscal year a grant to each health systems agency—

(1) with which there is in effect a designation agreement under section 1515(c),

(2) which has in effect an HSP and AIP reviewed by the Statewide Health Coordinating Council, and

(3) which, as determined under the review made under section 1535(c), is organized and operated in the manner prescribed by section 1512(b) and is performing its functions under section 1513 in a manner satisfactory to the Secretary,

to enable the agency to establish and maintain an Area Health Services Development Fund from which it may make grants and enter into contracts in accordance with section 1513(c)(3).

(b)(1) Except as provided in paragraph (2), the amount of any grant under subsection (a) shall be determined by the Secretary after taking into consideration the population of the health service area

for which the health systems agency is designated, the average family income of the area, and the supply of health services in the area.

(2) The amount of any grant under subsection (a) to a health systems agency for any fiscal year may not exceed the produce of $1 and the population of the health service area for which such agency is designated.

(c) No grant may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such an application shall be sumitted in such form and manner and contain such information as the Secretary may require.

(d) For the purpose of making payments pursuant to grants under subsection (a), there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1975, $75,000,000 for the fiscal year ending June 30, 1976, [and] $120,000,000 each for the fiscal years ending September 30, 1977, and September 30, 1978, *$25,000,000 for the fiscal year ending September 30, 1980, $40,000,000 for the fiscal year ending September 30, 1981, and $50,000,000 for the fiscal year ending September 30, 1982.*

Part E—Program To Assist and Encourage the Discontinuance of Unneeded Hospital Services

ESTABLISHMENT OF PROGRAM

Sec. 1641. The Secretary shall establish a program under which grants and technical assistance may be provided to hospitals to assist and encourage them to discontinue the provision of unneeded hospital services.

GRANTS

Sec. 1642. (a) Under the program established under section 1641, the Secretary may make grants to hospitals in operation on the date of the enactment of this part to assist the hospitals in discontinuing the provision of unneeded impatient hospital services or all hospital services.

(b) (1) A grant under subsection (a) shall be subject to such terms and condtions as the Secretary may by regulation prescribe to assure that the grant is used for the purpose for which it was made.

(2) The amount of any grant under subsection (a) shall be determined by the Secretary. The recipient of a grant may use the grant—

(A) in the case of a grantee which discontinues the provision of all hospital services, for the liquidation of the outstanding debt on the facilities of the grantee used for the provision of the services;

(B) in the case of a grantee which in discontinuing the provision of an inpatient hospital service converts or proposes to convert an identifiable part of a hospital facility used in the provision of the discontinued service to the delivery of another health service, for the planning, development (including construction and acquisition of equipment), and delivery of the health service;

(C) to provide reasonable termination pay for personnel of the grantee who will lose employment because of the discontinuance of hospital services made by the grantee, retraining of such personnel, assisting such personnel in securing employment, and other

costs of implementing arrangements described in subsection (d); and

(D) for such other costs which the Secretary determines may need to be incurred by the grantee in discontinuing hospital services.

(c)(1) No grant may be made under subsection (a) unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form and submitted in such manner as the Secretary may prescribe and shall include—

(A) a description of each service to be discontinued and, if a part of a hospital is to be converted to another use in connection with such discontinuance, a description of such part;

(B) an evaluation of the inpact of such discontinuance and conversion on the provision of health care in the health service area in which such service is provided;

(C) an estimate of the change in the applicant's costs which will result from such discontinuance and conversion; and

(D) such other information as the Secretary may require.

(2)(A) The health systems agency for the health service area in which is located an applicant for a grant under subsection (a) shall (i) in making the review of the applicant's application under section 1513(e), determine the need for each service proposed to be discontinued by the applicant, in the case of an application for the conversion of a facility, determine the need for each service which will be provided as a result of the conversion, and (iii) make a recommendation to the State Agency for the State in which the applicant is located respecting approval by the Secretary of the applicant's application.

(B) A State agency which has received a recommendation from a health systems agency under subparagraph (A) respecting an application shall, after consideration of such recommendation, make a recommendation to the Secretary respecting the approval by the Secretary of the application. A State Agency's recommendation under this subparagraph respecting the approval of an application (i) shall be based upon (I) the need for each service proposed to be discontinued by the applicant, (II) in the case of an application for the conversion of a facility, the need for each service which will be provided as a result of the conversion, and (III) such other criteria as the Secretary may prescribe, and (ii) shall be accompanied by the health systems agency recommendations made with respect to the approval of the approval of the application.

(3)(A) The Secretary may not approve an application for a grant under subsection (a)—

(i) if a State Agency recommended that the application not be approved, or

(ii) if the secretary is unable to determine that the cost of providing inpatient health services in the health service area in which the applicant is located will be les than if the inpatient health services proposed to be discontinued were not discontinued.

(B) In considering applications for grants under subsection (a) the Secretary shall consider the recommendations of health systems agencies and State Agencies and shall give special consideration to applications (i) which will assist health systems agencies and State Agencies

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to meet the goals in their health systems plans and State health plans, or (ii) which will result in the greatest reduction in hospital costs within a health service area.

(d) (1) Except as provided in paragraph (3), the Secretary may not approve an application submitted under subsection (c) unless the Secretary of Labor has, in acordance with paragraph (3), reviewed the application and notified the Secretary that the applicant has provided satisfactory assurances that the applicant will implement fair and equitable arrangements for the protection of the applicant's employees who will be affected by a discontinuance of hospital services, including, where appropriate, arrangements for the payment of reasonable termination pay, provision of retraining, and provision for priorities in reemployment by the applicant.

(2) The Secretary of Labor shall by regulation prescribe guidelines for arrangements for the protection of the interests of employees affected by the discontinuance of hospital services. The Secretary of Labor shall consult with the Secretary of Health, Education, and Welfare in the promulgation of such guidelines. Such guidelines shall first be promulgated not later than the promulgation of regulations by the Secretary for the administration of the grants authorized by subsection (a).

(3) The Secretary of Labor shall review each application submitted under subsection (c) to determine if the assurances described in paragraph (1) have been provided with the application and if they are satisfactory and shall notify the Secretary respecting his determination. Such review shall be completed wtihin—

(A) ninety days from the date of the receipt of the application from the Secretary of Health, Education, and Welfare, or

(B) one hundred and twenty days from such date if the Secretary of Labor has by regulation prescribed the circumstances under which the review will require at least one hundred and twenty days.

If within the applicable period, the Secretary of Labor does not notify the Secretary of Health, Education, and Welfare respecting his determination, the Secretary of Health, Education, and Welfare shall review the application to determine if the applicant has provided the assurances described in paragraph (1) and if such assurances are satisfactory. The Secretary may not approve the application unless he determines that such assurances have been provided and that they are satisfactory.

(e) The records and audits requirements of section 705 shall apply with respect to grants made under subsection (a).

(f) For purposes of this part, the term "hospital" means, with respect to any fiscal year, an institution (including a distinct part of an institution participating in the programs established under title XVIII of the Social Security Act)—

(1) which satisfies paragraphs (1) and (7) of section 1681(e) of such Act.

(2) imposes charges or accepts payments for services provided to patients, and

(3) the average duration of a patient's stay in which was thirty days or less in the preceding fiscal year,

but such term does not include a Federal hospital or a psychiatric hospital (as described in section 1861(f)(1) of the Social Security Act).

AUTHORIZATION OF APPROPRIATIONS

SEC. 1643. To make payments under grants under section 1642(a) there are authorized to be appropriated $50,000,000 for the fiscal year ending September 30, 1980, $75,000,000 for the fiscal year ending September 30, 1981, and $100,000,000 for the fiscal year ending September 30, 1982.

* * * * * * *

SECTION 303 OF THE COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

STATE PLANS

SEC. 303. (a) Any State desiring to participate in this part shall submit a State plan for carrying out its purposes. Such plan must—

(1) * * *

* * * * * * *

(16) contain such additional information and assurance as the Secretary may find necessary to carry out the provisions and purposes of this part.

Such plan shall be consistent with the State health plan in effect for such State under section 1524(c) of the Public Health Service Act. Each State plan shall pertain to the twelve-month period of the State fiscal year which commences in the calendar year in which the plan is submitted and shall be submitted not later than July 31 of each calendar year.

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SECTION 409 OF THE DRUG ABUSE OFFICE AND TREATMENT ACT OF 1972

§ 409. Formula grants.

(a) * * *

* * * * * * *

(e) Any State desiring to receive a grant under subsection (b)(2) or (b)(3) of this section shall submit to the Secretary, not later than July 31 of each calendar year, a State plan for planning, establishing, conducting, and coordinating projects for the development of more effective drug abuse prevention functions in the State and for evaluating the conduct of such functions in the State. Each State plan shall pertain to the twelve-month period of the State fiscal year which commences in the calendar year in which it is required to be submitted, and

(1) designate or establish a single State agency as the sole agency for the preparation and administration of the plan, or for supervising the preparation and administration of the plan;

* * * * * * *

(13) contain such additional information and assurance as the Secretary may find necessary to carry out the provisions of this section.

* * * * * * *

Such plan shall be consistent with the State health plan in effect for such State under section 1524(c) of the Public Health Service Act.

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COMMUNITY MENTAL HEALTH CENTERS ACT

PART A—PLANNING AND OPERATIONS ASSISTANCE

* * * * * * *

GENERAL PROVISIONS RESPECTING GRANTS UNDER THIS PART

SEC. 206. (a)[(1)] No grant may be made under this part to any entity or community mental health center in any State [unless a State plan for the provision of comprehensive mental health services within such State has been submitted to, and approved by, the Secretary under section 237] *for a fiscal year ending after September 30, 1981, unless a State health plan meeting the requirements of section 1524 of the Public Health Service Act is in effect for such State.*

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PART C—FACILITIES ASSISTANCE

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APPROVAL OF PROJECTS

SEC. 222. (a) For each project for a community mental health center facility [pursuant to a State plan approved under section 237], there shall be submitted to the Secretary, through the State agency of the State, an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the project, the application may be filed by one or more of such agencies. Such application shall set forth—

(1) a description of the site for such project;

(2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 236;

(3) except in the case of a leasing project, reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or nonprofit private agency which is to operate the community mental health center;

(4) reasonable assurance that adequate financial support will be available for the project and for its maintenance and operation when completed;

(5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a construction or remodeling project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

(6) a certification by the State agency of the Federal share for the project; and

(7) the assurances described in section 206(c).

Each applicant shall be afforded an opportunity for a hearing before the State agency respecting its application. For purposes of paragraph (3), the term "title" means a fee simple or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than fifty years undisturbed use and possession for the purposes of acquisition, remodeling, construction, or expansion of a facility and its operation.

(b) The Secretary shall approve an application submitted in accordance with subsection (a) if—

(1) sufficient funds to pay the Federal share for the project for which the application was submitted are available from the allotment to the State;

(2) the Secretary finds that the application meets the applicable requirements of subsection (a) [and the community mental health center for which the application was submitted will meet the requirements of the State plan (under section 237) of the State in which the project is located]; and

(3) the Secretary finds that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State[,] as determined [under] *by* the State [plan.] *agency.*

No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing. The Secretary may not approve an application under this part for a project for a facility for community mental health center or other entity which received a grant under section 220, 242, 243, 251, 256, 264, or 271 of this title (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975) from appropriations for a fiscal year ending before July 1, 1975, unless the Secretary determines that the application is for a project for a center or entity which upon completion of such project will be able to significantly expand its services and which demonstrates exceptional financial need for assistance under this part for such project. Amendment of any approved application shall be subject to approval in the same manner as an original application.

PAYMENTS

SEC. 223. (a) * * *

* * * * * * *

(c) (1) If the Secretary finds that—

(A) a State agency is not substantially complying [with the provisions required by section 237 to be in a State plan or] with regulations issued under section 236;

(B) any assurance required to be in an application filed under section 222 is not being carried out; *or*

(C) there is substantial failure to carry out plans and specifications approved by the Secretary under section 222 [; or],

[(D) adequate State funds are not being provided annually for the direct administration of a State plan approved under section 237,]

the Secretary may take the action authorized under paragraph (2) of this subsection if the finding was made after reasonable notice and an opportunity for hearing to the involved State agency.

(2) If the Secretary makes a finding described in paragraph (1), he may notify the involved State agency, which is the subject of the finding or which is connected with a project or State plan which is the subject of the finding, that—

(A) no further payments will be made to the State from allotments under section 227; or

(B) no further payments will be made from allotments under section 227 for any project or projects designated by the Secretary as being affected by the action or inaction referred to in subparagraph (A), (B), [(C), or (D)] *or* (*C*) of paragraphs (1),

as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotment may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

JUDICIAL REVIEW

SEC. 224. If—

(1) the Secretary refuses to approve an application for a project submitted under section 222, the State agency through which such application was submitted, or

(2) any State is dissatisfied with the Secretary's action under section 223(c) [or 237(c)], such State,

may appeal to the United States court of appeals for the circuit in which such State agency or State is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have

jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but, until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of facts and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

* * * * * * *

ALLOTMENTS TO STATES

SEC. 227. (a) In each fiscal year, the Secretary shall in accordance with regulations, make allotments, from the sums appropriated under section 228, to the States [(with State plans approved under section 237)] *(with State Health plans in effect under section 1524 of the Public Health Service Act after September 30, 1981)* on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need, of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, in any fiscal year may be less than $100,000. Sums so allotted to a State other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, in a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose in the next fiscal year (and in such year only), in addition to the sums allotted for year shall remain available to such State for such purpose in the next such State in such next fiscal year. Sums so allotted to the Virgin Islands, American Somoa, Guam, or the Trust Territory of the Pacific Islands in a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose in the next two fiscal years (and in such years only), in addition to the sums allotted to such State for such purpose in each of such next two fiscal years.

PART E—GENERAL PROVISIONS

DEFINITIONS

SEC. 235. For purposes of this title—

(1) The term "State" includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the Trust Territory of the Pacific Islands, and the District of Columbia.

(2) The term "State agency" means the State mental health authority for which grants are authorized under section 314[(d)] *(g)* of the Public Health Service Act.

(3) The term "Secretary" means the Secretary of Health, Education, and Welfare.

(4) The term "National Advisory Mental Health Council" means the National Advisory Mental Health Council established under section 217 of the Public Health Service Act.

REGULATIONS

SEC. 236. Regulations issued by the Secretary for the administration of this title shall include provisions applicable uniformly to all the States which—

(1) prescribe the general manner in which the State agency of a State shall determine the priority of projects for community mental health centers on the basis of the relative need of the different areas of the State for such centers and their services and require special consideration for projects on the basis of the extent to which a center to be assisted or established upon completion of a project [(A)] will, alone or in conjunction with other centers owned or operated by the applicant for the project or affiliated or associated with such applicant, provide comprehensive mental health services for residents of a particular community or communities [, or (B) will be part of or closely associated with a general hospital]; *and*

(2) prescribe general standards for facilities and equipment for centers of different classes and in different types of location [; and].

[(3) require that the State plan of a State submitted under section 237 provide for adequate community mental health centers for people residing in the State, and provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor.]

The National Advisory Mental Health Council shall be consulted by the Secretary before the issuance of regulations under this section.

[STATE PLAN

[SEC. 237. (a) A State plan for the provision of comprehensive mental health services within a State shall be comprised of the following two parts:

[(1) An administrative part containing provisions respecting the administration of the plan and related matters. Such part shall—

[(A) provide for the designation of a State advisory council to consult with the State agency in administering such plan, which council shall include (i) representatives of nongovernment organizations or groups, and of State agencies, concerned with the planning, operation, or use of community mental health centers or other mental health facilities, and (ii) representatives of consumers and providers of the services of such centers and facilities who are familiar with the need for such services;

[(B) provide that the State agency will make such reports in such form and containing such information as the Secre-

tary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports;

[(C) provide that the State agency will from time to time, but not less often than annually, review the State plan and submit to the Secretary appropriate modifications thereof which it considers necessary; and

[(D) include provisions, meeting such requirements as the Civil Service Commission may prescribe, relating to the establishment and maintenance of personnel standards on a merit basis.

[(2) A services and facilities part containing provisions respecting services to be offered within the State by community mental health centers and provisions respecting facilities for such centers. Such part shall—

[(A) be consistent with the provisions of the State plan prepared in accordance with section 1524(c)(2) of the Public Health Service Act or the State plan approved under section 314(a) of such Act, whichever is applicable, relating to the provision of mental health services;

[(B) set forth a program for community mental health centers within the State (i) which is based on a statewide inventory of existing facilities and a survey of need for the comprehensive mental health services described in section 201(b); (ii) which conforms with regulations prescribed by the Secretary under section 236; and (iii) which shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefore;

[(C) set forth the relative need, determined in accordance with the regulations prescribed under section 236, for the projects included in program described in subparagraph (B), and, in the case of projects under part C, provide for the completion of such projects in the order of such relative need;

[(D) emphasize the provision of outpatient services by community mental health centers as a preferable alternative to inpatient hospital services; and

[(E) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title and provide for enforcement of such standards with respect to projects approved by the Secretary under this title.

[(b) The State agency shall administer or supervise the administration of the State plan.

[(c) A State shall submit a State plan in such form and manner as the Secretary shall by regulation prescribe. The Secretary shall approve any State plan (and any modification thereof) which complies with the requirements of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

[(d)(1) At the request of any State, a portion of any allotment or allotments of such State under section 227 for any fiscal year shall be available to pay one-half (or such smaller share as the State may

request) of the expenditures found necessary by the Secretary for the proper and efficient administration of the provisions of the State plan approved under this section which relate to projects under part C for facilities for community mental health centers; except that not more than 5 per centum of the total of the allotments of such State for any fiscal year, or $50,000, whichever is less shall be available for such purpose. Amounts made available to any State under this paragraph from its allotment or allotments under section 227 for any fiscal year shall be available only for such expenditures (referred to in the preceding sentence) during such fiscal year or the following fiscal year. Payments of amounts due under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine.

[(2) Any amount paid under paragraph (1) to any State for any fiscal year for administration of the provisions of an approved State plan shall be paid on condition that there shall be expended from State sources for each year for administration of such provisions not less than the total amount expended for such purposes from such sources during the fiscal year ending June 30, 1968.]

STATE MENTAL HEALTH AUTHORITY

SEC. 237. (a) The State mental health authority shall—

(1) establish minimum standards for the maintenance and operation of community mental health services, including services provided through community mental health centers, which receive financial assistance under this title and provide for the enforcement of such standards and shall insure that the assistance provided under this title is in furtherance of the State health plan in effect for the State under section 1524 of the Public Health Service Act;

(2) establish a program for community mental health centers within the State (A) which is based on a statewide inventory of existing facilities and the need for the comprehensive mental health services described in section 201(b); (B) which shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor; (C) which is consistent with the State health plan in effect for such State under section 1524(c); and (D) which conforms with regulations prescribed by the Secretary under section 236;

(3) set forth the relative need, determined in accordance with regulations prescribed under section 236, for the projects included in a program described in pargraph (2); and

(4) make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports.

(b) The State mental health authority shall designate a State advisory council to consult with it in carrying out its functions under this title and title XV of the Public Health Service Act. Such council shall include (1) representatives of entities concerned with the planning, operation, or use of community mental health services, including the

services provided through community mental health centers, and other mental health facilities, and (2) representatives of consumers and providers of the services of such facilities who are familiar with the need for such services. A majority of the members of such council shall be individuals who are not providers of health care (as defined in section 1531(3) of the Public Health Service Act).

* * * * * * *

SECTION 1903 OF THE SOCIAL SECURITY ACT

PAYMENT TO STATES

SEC. 1903. (a) * * *

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(m)(1) * * *

(2)(A) * * *

(C) Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection of beginning on the date the entity [enters into a contract with the State under this title for the provision of health services on a prepaid risk basis] *qualifies as a health maintenance organization (as determined by the Secretary)*, whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

XVI. H.R. 3917—ADDITIONAL VIEWS

During the consideration of this bill, several instances of inappropriate use of the Certificate of Need program were brought to the attention of the Committee. For example, in the District of Columbia the Columbia Hospital for Women was recently granted a Certificate of Need for a renovation and modernization project on the condition that the hospital increase the number of women and black on its board of trustees, a condition bearing no relation to a determination of whether the project was needed. The Southern New Jersey Health Systems Agency has attempted to use Certificate of Need review for similar purposes.

There is also evidence that Certificate of Need review is being used by some Agencies as a means of effecting "back-door decertification" of existing health facilities and services by conditioning approval of an application for a new service for which need has been demonstrated upon termination of an existing and totally unrelated service.

In response to these abuses, the Subcommittee on Health and the Environment adopted an amendment which provided that Certificate of Need approval could not be conditioned upon compliance with a requirement not directly related to a determination of the need for the equipment, service, or expenditure for which the certificate was to be issued. This amendment was later deleted by the full Committee, partly in response to fears, in our opinion unfounded, that it would result in restrictions on the power of State Health Planning and Development Agencies to condition approval of Certificate of Need applications upon the ability of an applicant to adequately provide a needed service, the financial feasibility and cost of a project, and the provision of services to specific populations. Such restrictions were never intended. It has also been suggested that such a preemptive federal limitation should not be applied to state programs. This argument would have more force were it not for the fact that existing Certificate of Need programs are required by federal law and comprehensively regulated by the Department of HEW, and administered by agencies created and funded under the Health Planning and Resources Development Act. In any case, if a state wishes to decertify existing health care facilities or services it may do so directly.

The purpose of Certificate of Need programs is to insure that new health services are not offered and new health facilities are not built unless they are needed. Certificate of Need review was never intended to be used as a means of eliminating existing services, altering hospital boards of trustees, or forcing hospitals and other providers to take actions which are unrelated to the service for which an application is made.

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